

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MILTON ADAMS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-10-80 | | | | 2b. HOUR 9:08AM | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR July 26 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Gen. Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Government | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9000 Ardmore Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER ADAMS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NARSIS WIGGINS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes | | | | 16b. SOCIAL SECURITY NO. 426-14-3196 | | 17. INFORMANT ADDRESS Clara Adams 4002 Oaklawn Rd., Oxon Hill, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) possible myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) possible coronary artery disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 4 min 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/9 1980, to 5/10 1980, that (I) (we) last saw the deceased alive on 5/9 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Rodney L. Ellis, M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/10/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney L. Ellis | | | | | | 22e. ADDRESS 5100 Auth Way Marlow Heights Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-15-80 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover Md. | | | |
| 24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St., N.E., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |

possible coronary artery disease
possible myocardial infarction
possible coronary artery disease

[Faint handwritten notes and markings at the bottom of the page, including "10/12", "21A", and some illegible scribbles.]

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31** **32** **33** **34** **35** **36** **37** **38** **39** **40** **41** **42** **43** **44** **45** **46** **47** **48** **49** **50** **51** **52** **53** **54** **55** **56** **57** **58** **59** **60** **61** **62** **63** **64** **65** **66** **67** **68** **69** **70** **71** **72** **73** **74** **75** **76** **77** **78** **79** **80** **81** **82** **83** **84** **85** **86** **87** **88** **89** **90** **91** **92** **93** **94** **95** **96** **97** **98** **99** **100** **101** **102** **103** **104** **105** **106** **107** **108** **109** **110** **111** **112** **113** **114** **115** **116** **117** **118** **119** **120** **121** **122** **123** **124** **125** **126** **127** **128** **129** **130** **131** **132** **133** **134** **135** **136** **137** **138** **139** **140** **141** **142** **143** **144** **145** **146** **147** **148** **149** **150** **151** **152** **153** **154** **155** **156** **157** **158** **159** **160** **161** **162** **163** **164** **165** **166** **167** **168** **169** **170** **171** **172** **173** **174** **175** **176** **177** **178** **179** **180** **181** **182** **183** **184** **185** **186** **187** **188** **189** **190** **191** **192** **193** **194** **195** **196** **197** **198** **199** **200** **201** **202** **203** **204** **205** **206** **207** **208** **209** **210** **211** **212** **213** **214** **215** **216** **217** **218** **219** **220** **221** **222** **223** **224** **225** **226** **227** **228** **229** **230** **231** **232** **233** **234** **235** **236** **237** **238** **239** **240** **241** **242** **243** **244** **245** **246** **247** **248** **249** **250** **251** **252** **253** **254** **255** **256** **257** **258** **259** **260** **261** **262** **263** **264** **265** **266** **267** **268** **269** **270** **271** **272** **273** **274** **275** **276** **277** **278** **279** **280** **281** **282** **283** **284** **285** **286** **287** **288** **289** **290** **291** **292** **293** **294** **295** **296** **297** **298** **299** **300** **301** **302** **303** **304** **305** **306** **307** **308** **309** **310** **311** **312** **313** **314** **315** **316** **317** **318** **319** **320** **321** **322** **323** **324** **325** **326** **327** **328** **329** **330** **331** **332** **333** **334** **335** **336** **337** **338** **339** **340** **341** **342** **343** **344** **345** **346** **347** **348** **349** **350** **351** **352** **353** **354** **355** **356** **357** **358** **359** **360** **361** **362** **363** **364** **365** **366** **367** **368** **369** **370** **371** **372** **373** **374** **375** **376** **377** **378** **379** **380** **381** **382** **383** **384** **385** **386** **387** **388** **389** **390** **391** **392** **393** **394** **395** **396** **397** **398** **399** **400** **401** **402** **403** **404** **405** **406** **407** **408** **409** **410** **411** **412** **413** **414** **415** **416** **417** **418** **419** **420** **421** **422** **423** **424** **425** **426** **427** **428** **429** **430** **431** **432** **433** **434** **435** **436** **437** **438** **439** **440** **441** **442** **443** **444** **445** **446** **447** **448** **449** **450** **451** **452** **453** **454** **455** **456** **457** **458** **459** **460** **461**

MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|--|--|--|
| FOR 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 3013476 | |
| 1. DECEASED NAME (TYPE OR PRINT) Henry | | FIRST MIDDLE LAST ADLUNG | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-28 1980 2b. HOUR M | |
| 3. SEX Male 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1886 6. AGE (IN YEARS) (LAST BIRTHDAY) 93 YRS. | | 7c. DATE PRONOUNCED DEAD 5-28 1980 2d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Chesley | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital (DCH) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist Retired 12b. KIND OF BUSINESS OR INDUSTRY Navy Yard | |
| 13a. STATE Maryland 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Seabrook | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 6300 94th Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 214 52 3599 | |
| 17. INFORMANT Patricia A. Harris | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | TITLE (SPECIFY) M.D. | | DATE SIGNED 5/28/80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez | | ADDRESS 5009 Bayview Court, Landover, Md. 20785 | | | |
| 23a. BURIAL CREMATION/REMOVAL (SPECIFY) Burial | | 23b. DATE 5/31/80 | | 23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cem. | |
| 23d. LOCATION (CITY OR TOWN) Brentwood | | COUNTY P.G. | | STATE Md. | |
| 24a. TYPE OF FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A. | | ADDRESS Hyattsville, Maryland | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 25b. REGISTRAR'S SIGNATURE Jeffrey M. Gandy | |



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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 4 7 7 | |
|--|---|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Mary E. Anderson | | | | May 27, 1980 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Female | NEGRO | 5 18 1899 | | 81 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| VA. | USA | | | Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Clinton Md. | Southern Maryland Hospital | | HOUSEWIFE | | |
| 13a STATE | | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | |
| 1225 Fairmont Ave N.W. | | D. C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME (FIRST MIDDLE LAST) | | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 13e STREET ADDRESS | |
| (UNKNOWN) | | (UNKNOWN) | | 1225 Fairmont Ave. | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT (Son) ADDRESS | |
| NO | | 579509902 | | # 5 Manchester Pl. Sil. Spr., Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) unknown CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-22 19 80 to 5-27 19 80, that (I) (we) last saw the deceased alive on 5-27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b SIGNATURE David N. Koe MD | | 22c DATE SIGNED 5-28-80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 5/31/80 | | Maryland National | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 25a BY 1580 25b REGISTRAR | |
| Morrow & Woodford | | 1622 11th. St. Wash., D C | | Laurel, Md. | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|-----------------------------------|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Lizzie Viola | | ASHFORD | | | | | | MONTH DAY YEAR | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | 2c. DATE PRONOUNCED DEAD | |
| Female | | Black | | 6-22-03 | | 76 YRS. | | MONTHS DAYS HOURS MIN | | 5-21 1980 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 2d. HOUR | |
| N.C. | | U.S.A. | | WIDOWED | | DIVORCED | | Prince Georges | | M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | Princess Anne General Hospital | | None | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | Prince Geo. | | Seat Pleasant | | YES NO | | 122 Maryland Park Dr. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Steven | | Savannah | | 579820453 | | Arnette Swinner | | Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4292 | | Diabetic asthmatic selective cardiovascular disease | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | WHILE AT WORK NOT WHILE AT WORK | | STREET, FACTORY, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Augusto P. Rodriguez | | Deputy | | 5-21-80 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Augusto P. Rodriguez M.D. | | 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | |
| Burial | | 5-25-80 | | Church | | Duplin Co. | | N.C. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Frozen 389 Rt. 1, S.W. Wash. D.C. | | JUN 3 1980 | | [Signature] | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13479 | |
|---|--|-----------------------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARLAN DURANT AUSTIN | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED 5-16 19 80 | | 2b. HOUR 10 M 04 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 5 DAY 23 YEAR 57 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YR MONTHS 0 DAYS 0 MIN. | | 7c. DATE PRONOUNCED DEAD 5-16 19 80 | |
| 7a. BIRTHPLACE (STATE OR TERRITORY) North Carolina | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Gen Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Pvt. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Georges | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3101 Crafford Dr. 20022 | | | |
| 14. FATHER'S NAME FIRST Geater MIDDLE Austin LAST Austin | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Meda MIDDLE unk LAST unk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Korea | | | | 16b. SOCIAL SECURITY NO. 246-28-2954 | | 17. INFORMANT ADDRESS Mrs. Grace A. Austin, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) Ethanol dependency DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez M.D. | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5-17-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct. Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 20, 1980 | | 23c. PLACE OF BURIAL OR CREMATION St. Lukes Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Taylorsville, North Carolina | | | |
| 24. FUNERAL DIRECTOR NAME LEE Funeral Home, Clinton, Maryland ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1980 | | 25b. REGISTRAR'S SIGNATURE Notary Public N.C. | | | |

BP

TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]
DATE: 10-28-66
CLASS: [Illegible]
[Illegible text follows, including various administrative markings and stamps.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | 7 0 1 3 4 8 0 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | |
| JOSEPH L. BAILEY | | | | | 05-17-80 | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | |
| Male | | White | | 3-28-1913 | | 66 | | 10.35P.M. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Wash., D.C. | | U.S.A. | | | | PRINCE GEORGE'S COUNTY | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | | | | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Ret. Accountant | | U.S. Gov't. | | | | | | | |
| 13a STATE | | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? | | 13d STREET ADDRESS | | |
| Md. | | | Pr. Geo. | | Hyattsville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5721 - 39th Avenue | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| Francis A. Bailey | | | | | Mary C. Connor | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | |
| Yes | | | | | WWII | | A Helen W. Bailey (Wife) | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe congestive Heart Failure,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5-11-1980</u> , to <u>5-17-1980</u> , that (I) (we) lost saw the deceased alive on <u>5-17-1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b SIGNATURE <u>M. S. Nayar</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED <u>5-18-80</u> | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e ADDRESS | | | | | | |
| SANKARAN M. NAYAR, MD | | | 3717-38th AVE COTTAGE CITY, MD 20722 | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 5-20-80 | | Gate of Heaven | | Silver Spring, Mont. Md. | | |
| 24 FUNERAL DIRECTOR NAME | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | MAY 22 1980 | | <u>[Signature]</u> | | |

X

03-17-80 10:32P.M. J. JOSEPH

03-17-80 10:32P.M. J. JOSEPH

PRINCE GEORGE'S COUNTY D.C. U.S.A.

PRINCE GEORGE'S GENERAL HOSPITAL Ref. Room 1000 U.S. Hwy 10

1000 - 3000 Avenue

1000 - 3000 Avenue

1000 - 3000 Avenue

1000 - 3000 Avenue

1000 - 3000 Avenue

1000 - 3000 Avenue

1000 - 3000 Avenue

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1000 - 3000 Avenue

1000 - 3000 Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Lester S BALLARD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 7 1980 | | | 2b. HOUR 6:05 P_M | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS 60 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier | | 12b. KIND OF BUSINESS OR INDUSTRY Postal Service | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE Md. | | 13b COUNTY P.G. | | 13c CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6108 44th. Ave. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Aubrey Ballard | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Dearstine | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b SOCIAL SECURITY NO 578-03-7963 | | 17 INFORMANT Gary Ballard | | |
| | | | | | ADDRESS 127 Pinecrest Dr. Annapolis, Md. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One day Two years | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent pneumonitis | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 23 February, 19 68 to 7 May, 19 80 , that (I) (we) lost saw the deceased alive on 7 May, 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Carl J. Houmann | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7 May, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M. D. | | | | | 22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20840 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-9-80 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1980 | | 25b. REGISTRAR'S SIGNATURE Hickey/Kelch | | |



7. Article one

Article

Article

(and)

Article

Article

Article

Article

Article

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Article

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|---|----------------------------------|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) VITA Ferreira BALLATO | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05- 08-80 | | | 2b. HOUR 9.00PM | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1901 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South America | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST Domingos Vicino | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Acquila Mancusa | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-6195 | | 17 INFORMANT Louis D. Ferreira | | ADDRESS 356 Shamrock Blvd. Venice, Florida | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema.</u> (c) <u>Bilateral Pneumonitis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus. Hypertension.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-23-80</u> to <u>5-8-80</u> , that (I) (we) last saw the deceased alive on <u>5-8-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>V.P. Singh</u> | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRENDER P. SINGH | | 22e. ADDRESS 3700 EAST WEST Hwy HYATTSVILLE Md. 20782 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md. | | | |
| 24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. | | | | ADDRESS Hyattsville, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Robert C. Cuddy</u> | |



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

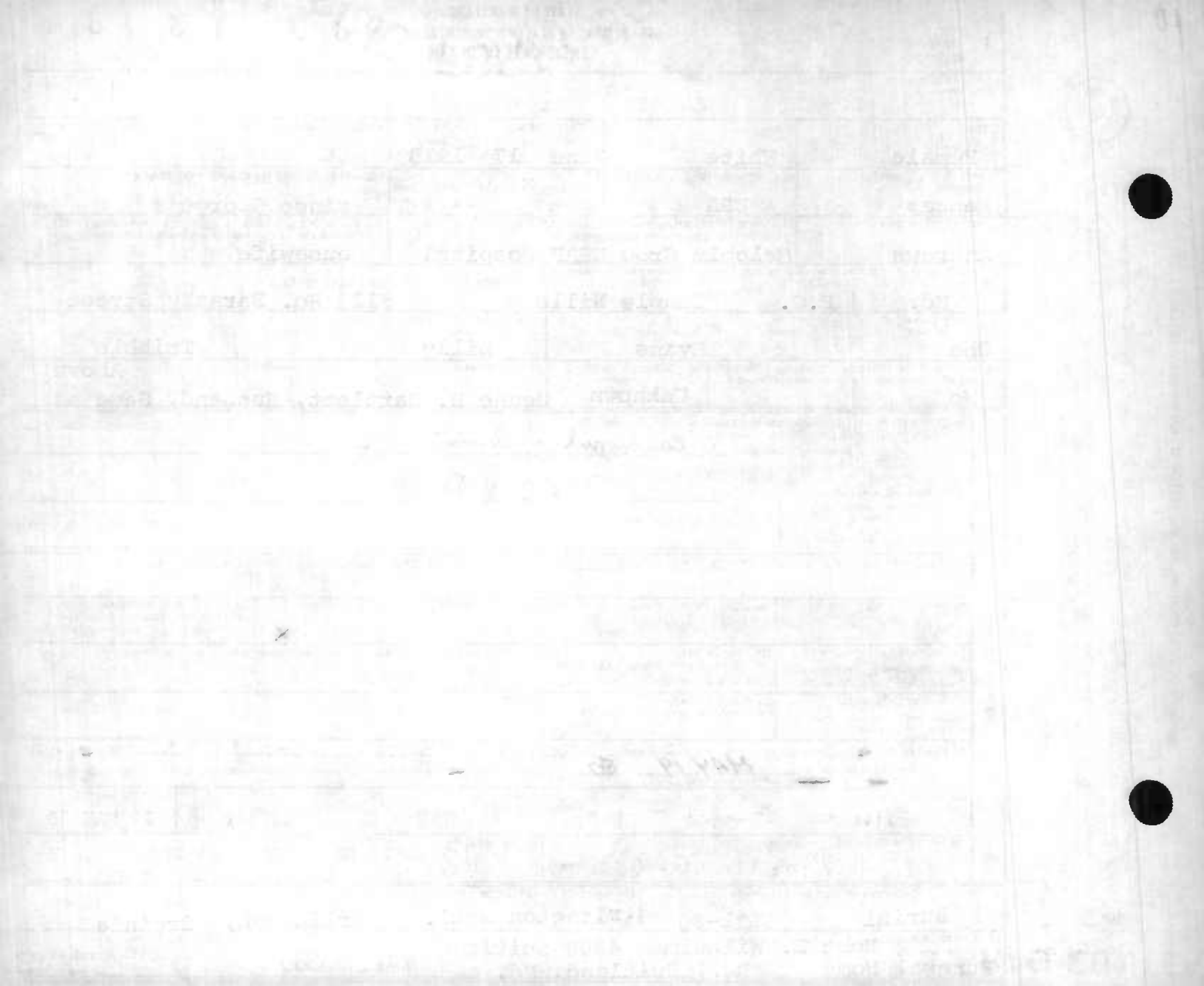
| | | | | | | | |
|---|-------------------------|--|--------------------------------|---|------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Daniel Webster BARRY | | 2b. DATE KNOWN OF DEATH ESTIMATED 5-25-80 | | 2c. DATE PRONOUNCED 5-25-80 | | 2d. HOUR 9A | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH 8-25-15-69 | 6. AGE (IN YEARS) 69 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Marlow Hts. 4017 25th Avenue | | 12. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE Maryland | | 13b. COUNTY Prince George | |
| 13c. CITY OR TOWN Villacrest Hts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4017 25th Avenue | | 14. FATHER'S NAME FIRST George MIDDLE A LAST BARRY | |
| 15. MOTHER'S MAIDEN NAME FIRST Augusta MIDDLE V. LAST Thomas | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1942-1945 579-05-4700 | | 17. INFORMANT Betty Barry - SAME AS Item #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 19a. DATE OF OPERATION | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | TITLE (SPECIFY) Deputy | | DATE SIGNED 5-25-80 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | |
| 23b. DATE 5-29-80 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland | | 24. FUNERAL DIRECTOR NAME Vann + Wms. ADDRESS 4804 9A Ave. N.W. | |
| 25a. DATE REC'D. BY REGISTRAR MAY 29 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 25c. REGISTRAR'S NAME Augusto P. Rodriguez M.D. | | 25d. ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY FRANCIS BARTLETT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 19 1980 | | | 2b. HOUR 4:18A M | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR June 17 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | |
| 10 CITY OR TOWN OF DEATH Andrews | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. P.G. Temple Hills | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5114 So. Barnaby Street | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Obe Evans | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Tribble | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO Unknown | | 17 INFORMANT ADDRESS Deane H. Bartlett, Husband, Same as Above | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiomyopathy - arrest.</u> 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>CO & P</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>May 7</u> 19 <u>80</u> , to <u>May 19</u> 19 <u>80</u> , that (we) lost saw the deceased alive on <u>MAY 19</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Martin Greget MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 19 MAY 80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Greget MD | | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-21-80 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | | | | |
| 24 FUNERAL DIRECTOR NAME Robt E. Wilhelm | | | | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

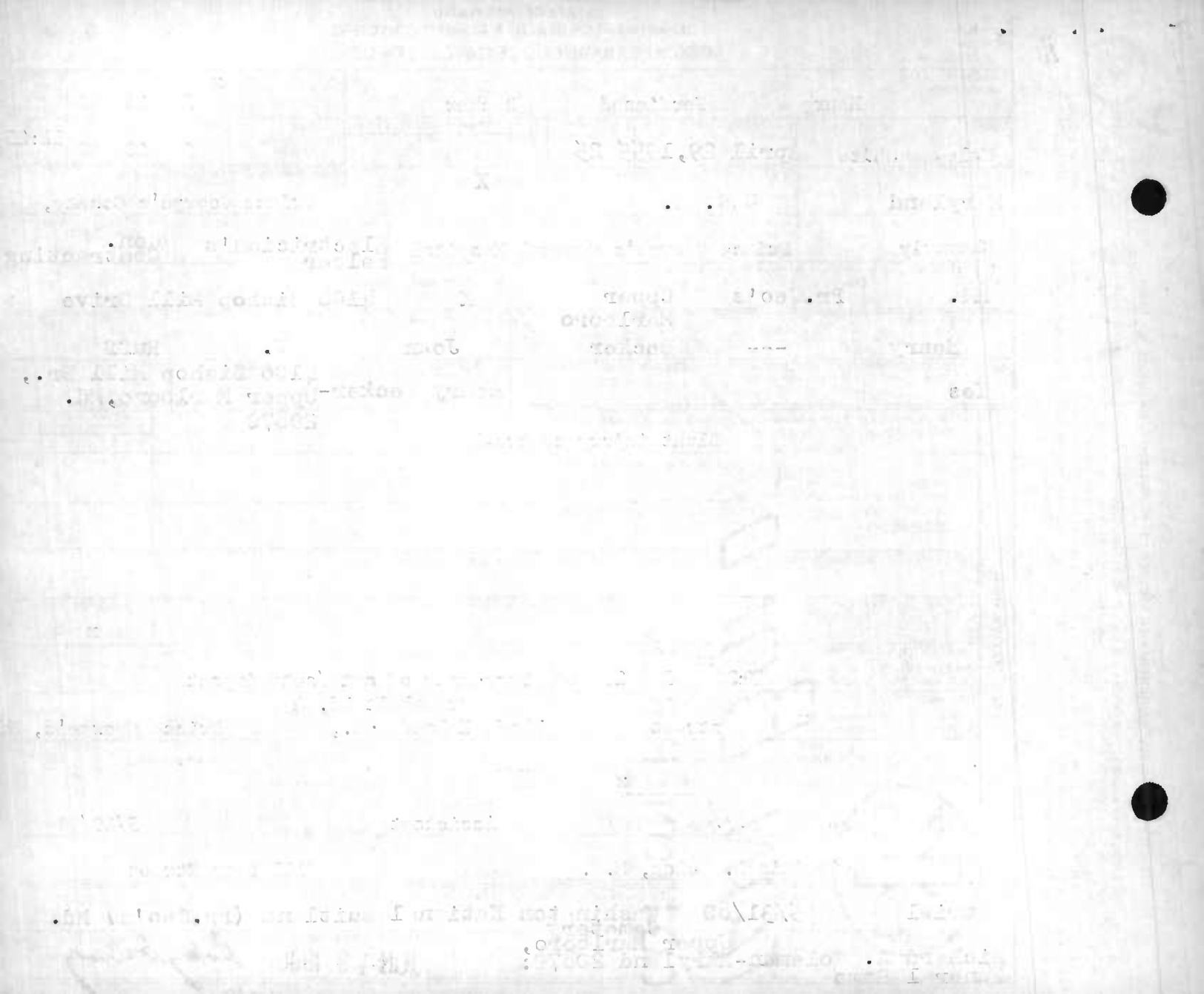
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 3 4 8 5 | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES ALBERT BAYNE | | | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 9 1980 | | | 2b HOUR 7:55P M | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB CAMP SPRINGS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDCEN | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heating Engineer | | 12b KIND OF BUSINESS OR INDUSTRY A.A.F. Base | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | | | 13b CITY OR TOWN PRINCE GEO FORRESTVILLE | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN WILTON BAYNE | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE LYNN SAUBERLICH | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b SOCIAL SECURITY NO W.W.II Navy 297 03 3715 | | 17 INFORMANT ADDRESS Charlene A. Lerner Oxon Hill, Md. 12503 Parkton St. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 492- DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA AND LUNG CA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). CHRONIC ALCOHOLISM AND GI DISEASES | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 9 MAY 19 80 , to 9 MAY 19 80 , that (I) (we) last saw the deceased alive on DID NOT 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Thomas F. Daley M.D. DEGREE M.D. | | | | | | 22c DATE SIGNED 9 MAY 80 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS F. DALEY M.D. | | | | | | 22e ADDRESS Malcolm Grow U.S.A.F. Med. Cen. Andrews A.F.B. Camp Springs, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5-13-80 | | 23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md. | | |
| 24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | | 25a DATE REC'D BY REGISTRAR MAY 15 1980 | | 25b REGISTRAR SIGNATURE | |

0351 6 1 YAM

09-55-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 0 | 1 | 3 | 4 | 8 | 7 |
|---|--|--|--|--|-----------------------------------|--|--|---|-------------------------------------|---|---|-----------------------------------|----------------------------------|-----------------|---------------------------|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a DATE OF DEATH | | | 7a HOUR | | | |
| McKinley BELTON | | | | | | | | | | May 29, 1980 | | | 10:20 ^a M | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | | Black | | | 3/3/1915 | | | 59 YRS | | | MONTHS | | DAYS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| SC | | | USA | | | | | | Prince George County MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Glenn Dale | | | Glenn Dale Hospital | | | | | | | Construction | | | None | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d INSIDE CITY LIMITS? | | 13c STREET ADDRESS | | | | |
| 13a STATE DC | | | | | | | | | | 13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c 1140 N Capital | | | | |
| 14 FATHER'S NAME | | | | | | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| Ruben Belton | | | | | | | | | | Nannie Belton | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | |
| No | | | | | | | | | | 250 22 3453 | | Pearl Belton, Wife 1140 N Capital | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism | | | | | | | | | | minutes | | | | | | |
| 436- DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Cerebrovascular accident | | | | | | | | | | days | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | |
| Recurrent urinary tract infection and chronic renal insufficiency | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY | | | 21f LOCATION | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 20, 1976, to May 29, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 29, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | DEGREE | | 22c DATE SIGNED | | | | |
| James Wills, M.D. | | | | | | | | | | | | May 29, 1980 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e ADDRESS | | | | | | |
| James W. Wills, M.D. | | | | | | | | | | Glenn Dale Hospital Glenn Dale, Maryland 20769 | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION | | | | | | | | |
| Burial | | | 5/5/80 | | Washington N | | | ational. Suitland Maryland | | | | | | | | |
| 24a FUNERAL DIRECTOR | | | | | | | | | | 24b ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | |
| Home Inc | | | | | | | | | | 1425 | | JUN 11 1980 | | | Dorothy McCurdy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) JOSEF BEROLZHEIMER | | | | | 2a DATE OF DEATH MONTH DAY YEAR 05 28 80 | | | 2b HOUR 3:25A.M. | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 10 05 00 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Econ. U. S. Gov't. | | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Pr. George 13c CITY OR TOWN Camp Springs | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 5504 Yorkshire Dr. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Franz Berolzheimier | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Ottenheimer | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 132-14-0552M | | 17 INFORMANT ADDRESS Same as Above Dorothea Berolzheimier, Wife, | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Adenocarcinoma of the urinary bladder with 1889 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) metastases DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Diabetes Mellitus/ Hypertensive Cardiovascular Disease; COPD | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from April 19 79 , to May 8 28/ 19 80 , that (I) (we) lost saw the deceased alive on May 28th 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <i>Victor S. Chupkovich</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED 5/28/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D. | | | | 22e ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL Cremation | | 23b DATE 5-29-80 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., md. | | | |
| 24 FUNERAL DIRECTOR NAME Robt E Wilhelm | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | DATE RECD BY REGISTRAR JUN 9 1980 | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|--|---|--|----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| Grace Bianco | | | | | 5 30 80 1:10pm | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | Caucasian | | MONTH DAY YEAR | | 92 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 47 WASH. D.C. | | U.S. | | | | Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 90 ADELPHI | | MANOR CARE ADELPHI | | | | Housewife | | at home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| Maryland Pr. George Hyattsville | | | | | 6923-Randolph Street | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | |
| 46 SYLVESTER - Lalicata | | | | | Carmela Monaco | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Niece) | | ADDRESS | | | |
| 1 No | | 579-01-0295 | | Lucille CROCKETT | | 6923 RANDOLPH ST. Hyattsville, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | 2 mins | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease | | | | | | | | 720 yrs. | |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) advanced age | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from July 1, 19 77, to May 30, 19 80, that (b) (we) lost saw the deceased alive on May 26, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| Frank E. Goldberg | | | | | M.D. | | | 5/30/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Frank E. Goldberg | | | | | 1140 Varnum St. NE, Wash., D.C. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | June 2, 1980 | | St. Mary's Cemetery | | Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., D.C. 20002 | | | | | JUN 4 1980 | | | | |

BP

1. The following information is being provided to you for your information only. It is not intended to be used for any other purpose.

June 2, 1960
Mr. J. Edgar Hoover
Washington, D.C.

LEADER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 8 0 1 3 4 9 0 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LOUISA M. BILLINGS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 27 1980 12:00P M | | | | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 1 31 1889 | | 6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia | | 7c. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Forestville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3531 Pinevale Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Wittmaier | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizetta Krieg | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 136-26-2973 | | 17. INFORMANT P.O. Box 1927 Cape Coral Fla. Elizabeth B. Johnson | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute Congestive Heart Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4-26-19 to 5-26-19, that (I/we) last saw the deceased alive on 5-26-19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (we did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE T. Cleary MD | | | | DEGREE | | | | 22c. DATE SIGNED 5-27-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Cleary, MD. | | | | 22e. ADDRESS Clinton, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Roslyn Pa. | | | |
| 24. FUNERAL DIRECTOR NAME Pee Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| 633 Old Alexander Ferry Road Clinton Md. | | | | | | | | | |



one
Name
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2/30/80
Initial
Date
Name

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 0 1 3 4 9 1 | |
|--|----------------------|---|-----------------------------|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Andrew BOARDLEY | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 5/24 19 80 | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH 9-11-44 | 6. AGE (IN YEARS) 35 | 7. IF UNDER 1 YR. MONTHS XX DAYS XX | 8. IF UNDER 24 HRS. HOURS XX MIN XX | 2c. DATE PRONOUNCED (DEA) 5/24 19 80 | | 2d. HOUR 11:00 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH (The City) | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Prince Georges General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY PRIVATE | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN PRINCE GEORGE'S | | 13c. CITY OR TOWN SUITLAND | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4744 HOMER AVENUE, | | | |
| 14. FATHER'S NAME JULIUS J. BOARDLEY | | | | 15. MOTHER'S MAIDEN NAME LOLA LANE | | 16. SOCIAL SECURITY NO. 217-42-2769 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 17. INFORMANT BRANDYWINE, MARYLAND | | 17. INFORMANT JUDITH P. BOARDLEY/wife/14307-S-SPRING RD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke, he arteriosclerotic cardiac vascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic Alcoholism | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5/25/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | 23b. DATE MAY 30, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER PG MARYLAND | | | |
| 24. FUNERAL DIRECTOR ROLLINS FUNERAL HOME, INC. | | | | | | 25a. DATE JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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RELEASED TO PMD BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LAWRENCE JOSEPH BOMBERGER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 19 1980 | | 2b. HOUR 11:03AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov 9 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | |
| 12. CITY OR TOWN OF DEATH Lanham | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't Employee | | 15. KIND OF BUSINESS OR INDUSTRY Env. Prot. Agen | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md. | | | | | 16b. CITY OR TOWN Prince George | | 16c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16d. STREET ADDRESS 3E Crescent Rd. | |
| 17. FATHER'S NAME FIRST MIDDLE LAST Frank Bomberger | | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Blunden | | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | | 20. SOCIAL SECURITY NO 405 10 8774 | | 21. INFORMANT ADDRESS Mrs. Hulda Bomberger Greenbelt, Md. | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 3489 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe brachial aneurysm</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days 1 month 1 month | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 23a. DATE OF OPERATION | | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 24a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 26, PART 1 OR PART 2) | | | | |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 26c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 27. I certify that (I) (this hospital) attended the deceased from <u>April 12th</u> 19 <u>80</u> to <u>May 19th</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 18th</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 28. SIGNATURE <u>Till Bergemann</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 29. DATE SIGNED May 19th 1980 | | | |
| 30. PHYSICIAN'S NAME (TYPE OR PRINT) Till Bergemann, M.D. | | | | | 31. ADDRESS 115 Centerway, Greenbelt, Md. 20770 | | | | | |
| 32. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 33. DATE May 21, 1980 | | 34. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery | | 35. LOCATION CITY OR TOWN COUNTY STATE Elk Garden Mineral W.Va. | | | |
| 36. FUNERAL DIRECTOR NAME David A. Burdock | | | | | 37. ADDRESS Kitzmiller, Md. 21538 | | 38. DATE REC'D. BY REGISTRAR MAY 20 1980 | | 39. REGISTRAR'S SIGNATURE | |

827 • J. Neurosci., June 29, 2006 • 26(26):825–831



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 4 9 3

REG. NO.

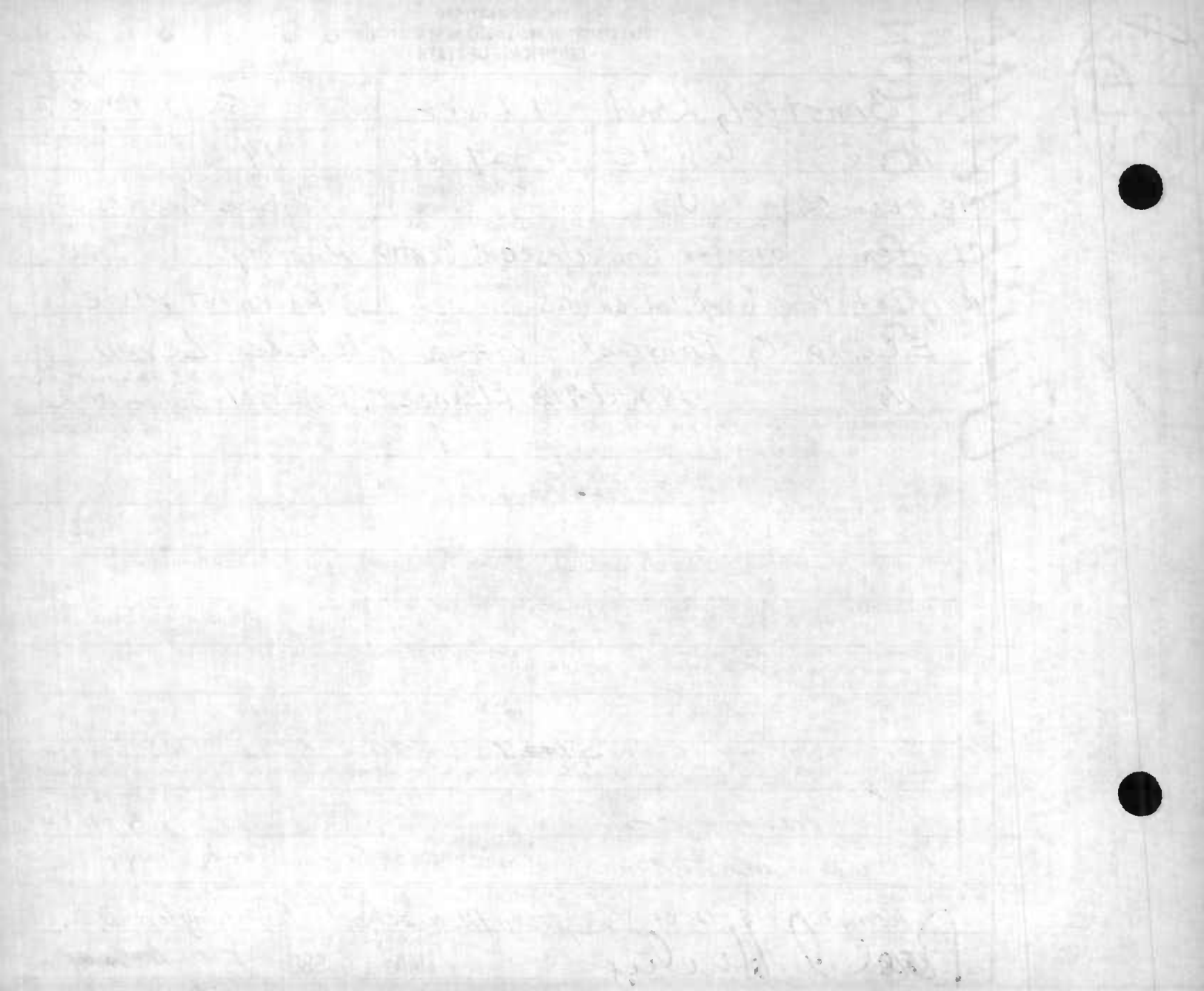
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bonsteel, Lloyd Oliver | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 12 80 | | | | 2b. HOUR 10 MIN 5 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 27 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cleveland Ohio | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY LAW | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Indian Head | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 23 Fairmont Place | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edward O. Bonsteel | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Adelaide Levan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 282-07-9433 | | 17. INFORMANT ADDRESS Eleanor C. Bonsteel Indian Head | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 185- DUE TO, OR AS A CONSEQUENCE OF (b) Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2m | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/12/80 , 19 80 , to 5/12 , 19 80 , that (I) (we) last saw the deceased alive on 5/12 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. Morgan DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/12/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. A. MORGAN | | | | 22e. ADDRESS 4235 28th Ave NW NW 20431 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 5-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY Georgetown Med School | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | | | |
| 24. FUNERAL DIRECTOR (NAME) Paul J. Hurley ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR MAY 16 1980 | | 25b. REGISTRAR'S SIGNATURE Paul J. Hurley | | | |

IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



8

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8013494

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet Brady | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-16-80 | | | 2b. HOUR 11 ²⁵ AM | |
| 3. SEX F | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 9-10-96 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? U-S | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH P. G. MD. | |
| 10. CITY OR TOWN OF DEATH Adelphi | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Manor Care | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Admi Asst | |
| 12b. KIND OF BUSINESS OR INDUSTRY C&P Telephone C | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Baldensburg | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 410-53 Ave | | 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Moore | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Mangum | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None | | | | | |
| 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT James W. Brady | | ADDRESS 3322 Gum Wood Drive Hyattsville, Md. 20783 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 2639 } DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition (c) Senile dementia DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASCVD, COPD, S/P Pneumonitis, Anemia, CHF, Cardiac arrhythmia: PVC | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 2-13-79, 19 to 5-16-80, 19, that (1) was last saw the deceased alive on 5-16-80, 19, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (2) we (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE J B Patrick III MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-17-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick III MD | | 22e. ADDRESS 9221 Colesville Rd Silver Spring Md 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/20/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN 20023 COUNTY STATE 4111 Pa. Ave Suitland Md. | |
| 24. FUNERAL DIRECTOR NAME J. William Lee's Sons Co. | | ADDRESS 300 4th St. N.E. D.C. | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1980 | | 25b. REGISTRAR'S SIGNATURE L. J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

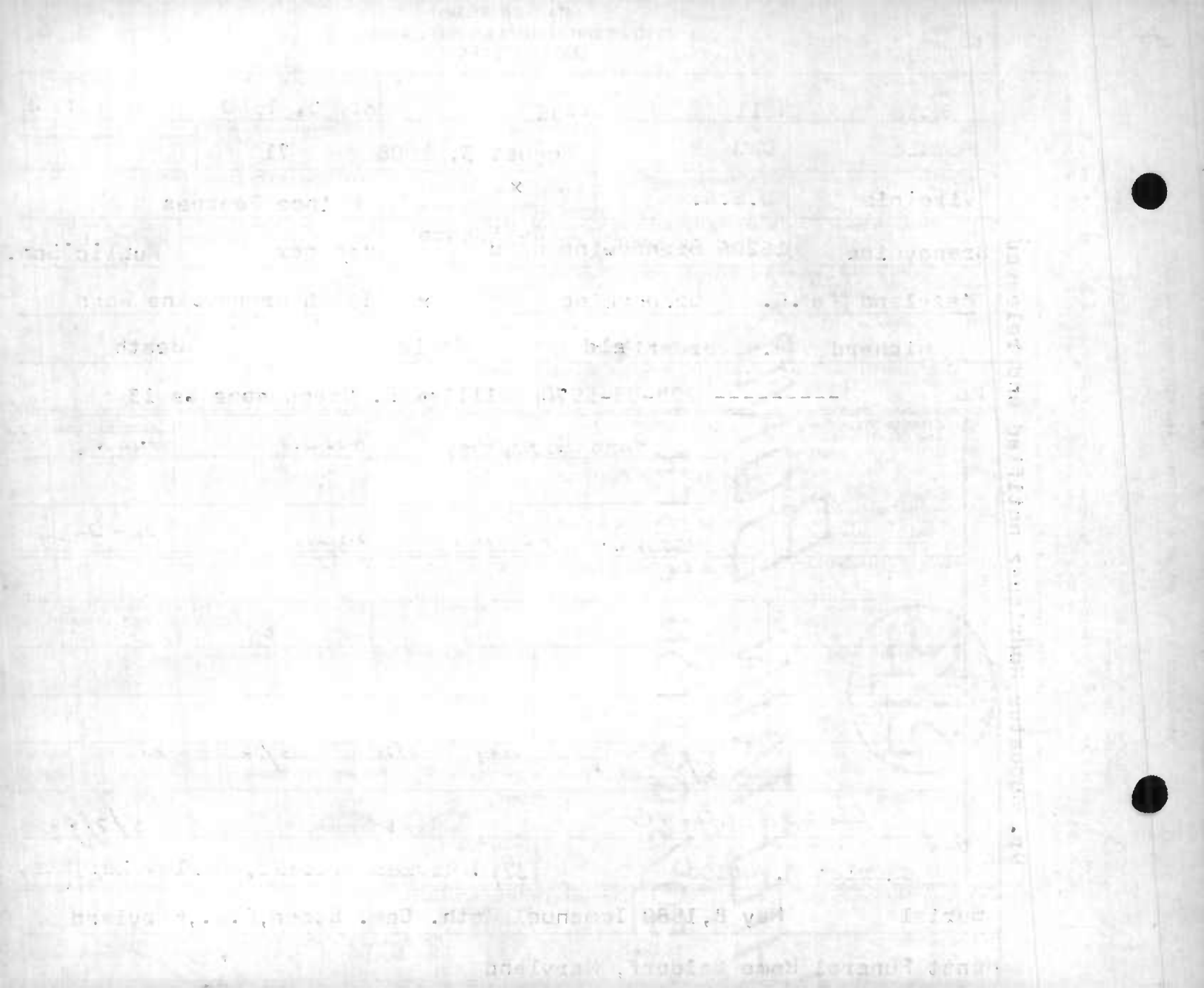
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Augustus Rodriguez notified and released

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|---|-------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 3 4 9 5 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Rosa Nell Bragg | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 6, 1980 | | | | | 2b. HOUR 12:10 PM |
| 3 SEX Female | | 4 RACE Cau | | 5 DATE OF BIRTH MONTH DAY YEAR August 3, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | |
| 10. CITY OR TOWN OF DEATH Brandywine | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16206 Brandywine Road Residence | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Public Sch. | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Brandywine | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 16206 Brandywine Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard A. Brumfield | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Heath | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-05-5970 | | 17. INFORMANT ADDRESS William E. Bragg same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Pulmonary Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease 20-3029 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minor | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3710 Riviera Street, Marlow Heights, MD | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 1978 to 5/6 1980 that (I) (we) lost saw the deceased alive on 5/5 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Charles F. Colao | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5/7/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Colao | | | | | 22e. ADDRESS 3710 Riviera Street, Marlow Heights, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE May 8, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Immanuel Meth. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baden, P.G., Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home Waldorf, Maryland | | | | | 25a. DATE REC'D BY REGISTRAR MAY 13 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony M. Brady | | | |



2401 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

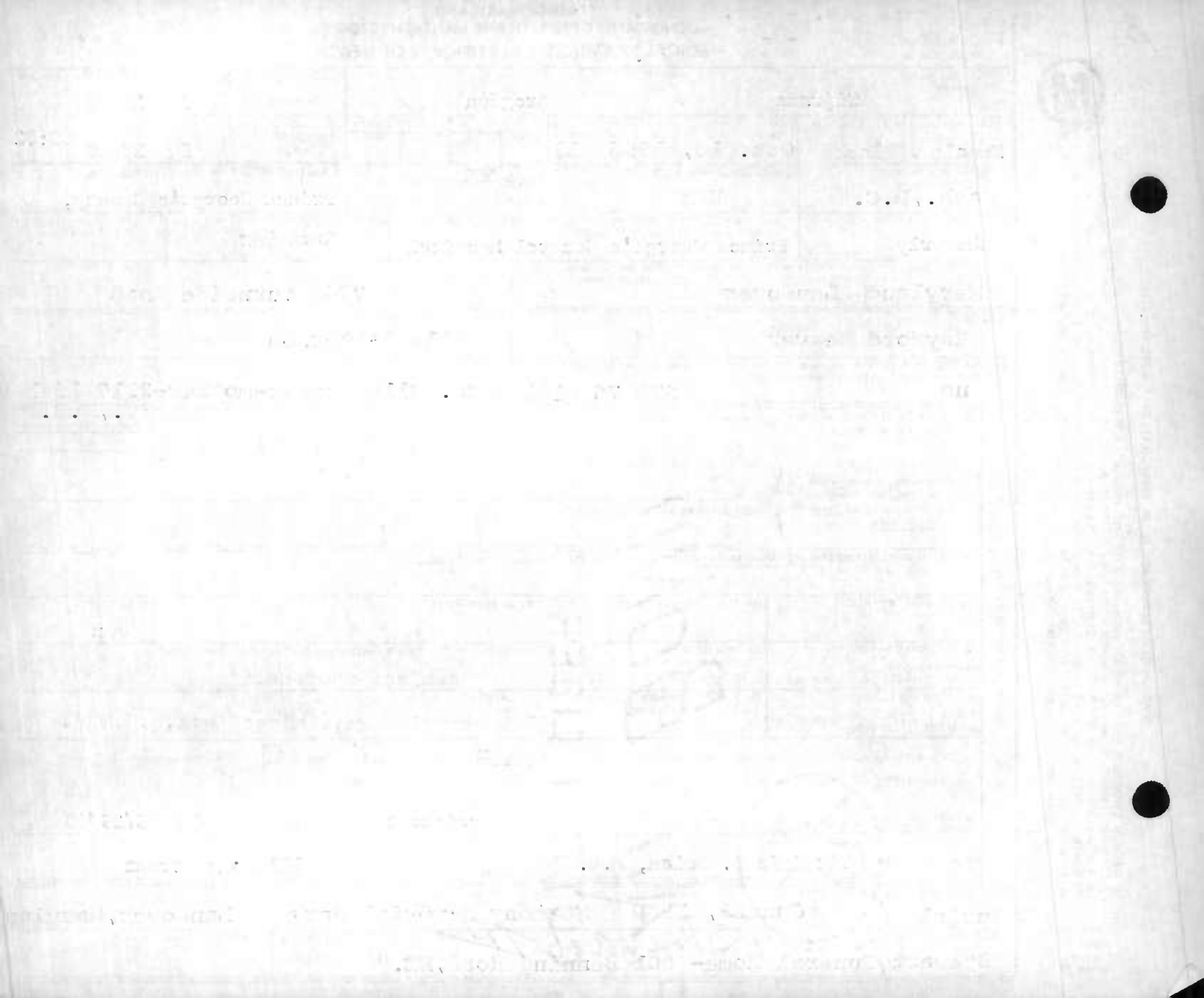
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 17 G 546 8/12/80 GB | | | | | | | | | |
|--|--|--|--|--|---|--|---------------------------|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8013496 | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) HILDA R. BRAXTON | | | | | 2a DATE OF DEATH MONTH DAY YEAR 05-30-80 | | 2b HOUR 11:05PM | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR MAR 22, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELEVATOR OPERATOR | | 12b KIND OF BUSINESS OR INDUSTRY GOVERNMENT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE MD | | 13b COUNTY P.G. | | 13c CITY OR TOWN SUITLAND | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 1917 CAMPBELL DR. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ELIAS CAMPBELL | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY BLAIR | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO 577 100122 | | 17 INFORMANT ADDRESS Wilbur BRAXTON HUSBAND 1917 CAMPBELL DR. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 5750 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Cholecystitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple Sclerosis, Shigellosis | | | | | | | | | |
| 19a DATE OF OPERATION 5/14/80 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Cholecystitis | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5/12/80 to 5/20/80 , that (I) (we) lost saw the deceased alive on 5/20/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE V. P. Chandra | | | | DEGREE MD | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Venkatesh Prasad Chandra | | | | 22e ADDRESS 6001 Landover Rd, Cheverly, MD 20785 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JUN 3, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, MD | | | |
| 24 FUNERAL DIRECTOR ALEXANDER S. POPE | | | | ADDRESS 2617 PENNSYLVANIA AVE S.E. | | 25. DATE RECD. BY REGISTRAR 1980 REGISTRAR'S SIGNATURE | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1. STATE REGISTRAR | | | | | | | | | | 2. DATE KNOWN OF DEATH | | | | | | | | | | 7b. HOUR | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|--|--|--|--|--------------------------------------|--|----------|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2. DATE KNOWN OF DEATH | | | | | | | | | | 7b. HOUR | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | |
| Tijwana Brogdon | | | | | | | | | | 5 28, 80 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 24 HRS. | | 8. DATE PRONOUNCED DEAD | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | Black | | Oct. 18, 1956 | | 23 | | MONTHS DAYS HOURS MIN | | 5 28, 80 | | Prince George's County, MD. | | 9:02 PM | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wash., D.C. | | | | USA | | | | | | | | Prince George's County, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cheverly | | | | Prince George's General Hospital | | | | Cashier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Landover | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7769 Burnside Road | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rayford Weaver | | | | | | | | | | Ella Patterson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | |
| no | | | | | | | | | | 578 76 0181 | | | | | | | | | | Mrs. Ella Weaver-mother-2317 15th S | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | 19. DATE OF OPERATION | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | 21a. EXTERNAL CAUSE WAS | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED | | | | | | | | | |
| 9550 IMMEDIATE CAUSE (a) Gunshot wound of abdomen (handgun) | | | | | | | | | | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | ? P.M. 5/28/80 | | | | | | | | | | subject shot self | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | | | WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | | | | | home | | | | | | | | | | 7769 Burnside Rd., Palmer Park, P.G., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| death resulted from: | | | | | | | | | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Virginia L. Dolan | | | | | | | | | | Assistant | | | | | | | | | | 5/29/80 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | | | | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | |
| Burial | | | | | | | | | | June 3, 1980 | | | | | | | | | | Harmony Memorial Park | | | | | | | | | | Landover, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR | | | | | | | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Stewart | | | | | | | | | | JUN 4 1980 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 4 9 8 | | | |
|--|---|--|---|---|---|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) ALFRED E. BROOKS | | | | 2a DATE OF DEATH MONTH DAY YEAR 05-23-80 | | 2b HOUR 10:42PM | |
| 3 SEX M | 4 RACE N | 5 DATE OF BIRTH MONTH DAY YEAR Apr 11 1914 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR # UNDER 24 HRS MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES GENERAL HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b KIND OF BUSINESS OR INDUSTRY U.S. Govt | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a STATE M | 13b COUNTY P.G. | 13c CITY OR TOWN Farm Mount Hts | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS 729-60th Pl. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Brooks | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Lewis | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO None UNKNOWN | | 17 INFORMANT ADDRESS Lawrence Brooks 708-59th Ave | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary arrest of unknown etiology | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4275 } DUE TO, OR AS A CONSEQUENCE OF (b) oliguria of metabolic acidosis of unknown etiology | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-19-80 to 5-23-80 , that (I) (we) last saw the deceased alive on 5-23-80 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Mukesh Luhar | | | | DEGREE | | 22c DATE SIGNED 5/24/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Mukesh Luhar | | | | 22e ADDRESS HOSPITAL DR. CHEVERLY, MD. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE 5-28-80 | | 23c NAME OF CEMETERY OR CREMATORY HARMONY | | 23d LOCATION CITY OR TOWN COUNTY STATE Highland PK MD | |
| 24 FUNERAL DIRECTOR NAME H.S. Washington & Sons ADDRESS 4925 Nannie Bourne | | | | 25a DATE REC'D. BY REGISTRAR JUN 4 1980 | | 25b REGISTRAR'S SIGNATURE [Signature] | |

PRINCE GEORGE

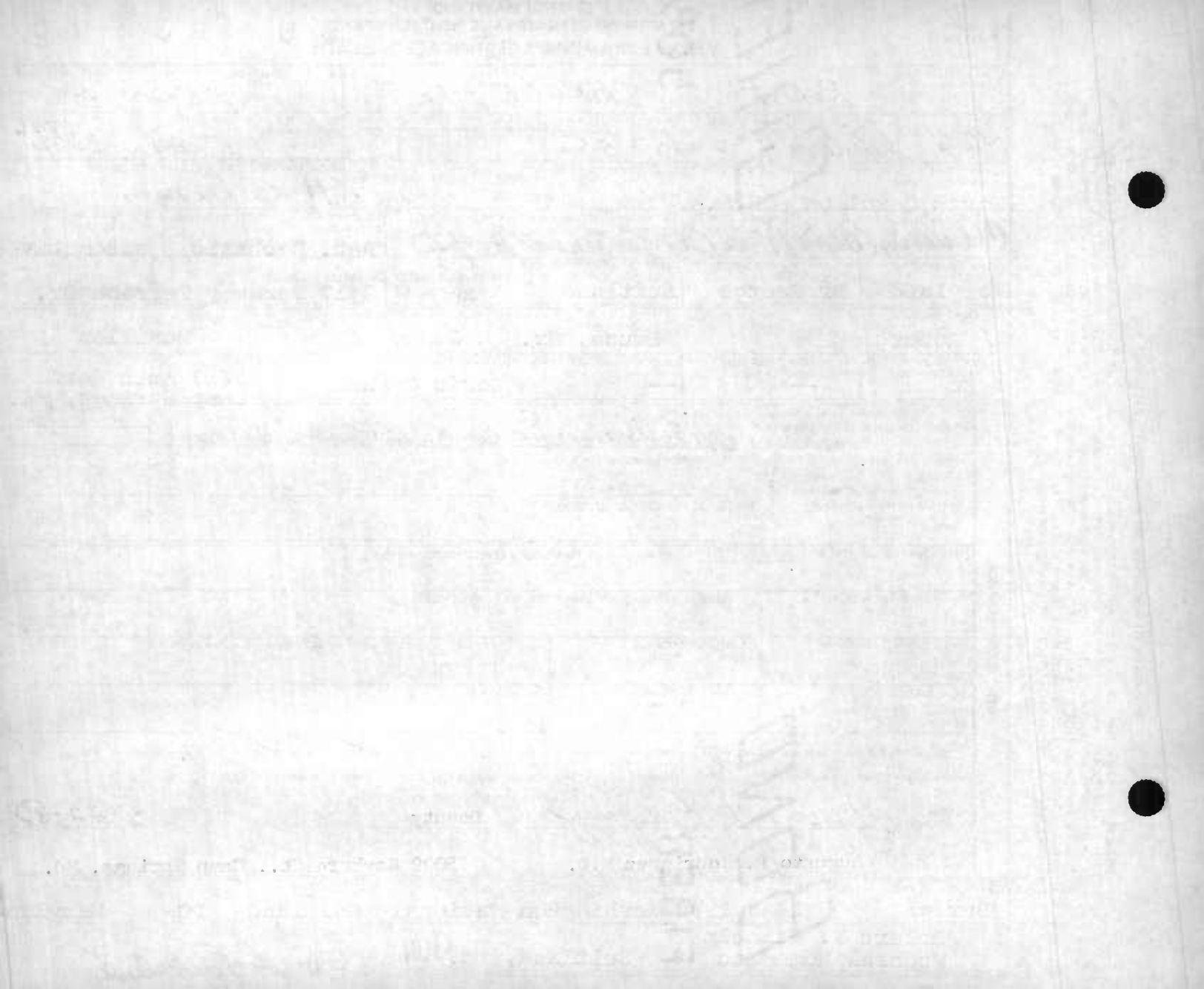
HOSPITAL DR. CLEVELY, HO.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13499 | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|---|---|--|--|--|--|--|---|--|---|---|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HENRY Franklin BROWN Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 5 DAY 15 YEAR 1980 | | 2b. HOUR 3:30 P.M. | | | | | | | | | | | | |
| 3. SEX male | | 4. RACE negro | | 5. DATE OF BIRTH MONTH 9 DAY 3 YEAR 1949 | | 6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD MONTH 5 DAY 15 YEAR 1980 | | 2d. HOUR 3:30 P.M. | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Va. Disability | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE Md. | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5233 Kenilworth Ave. Apt. 100 | | | | | | |
| 14. FATHER'S NAME FIRST Henry MIDDLE Brown LAST Brown | | | | | 15. MOTHER'S MAIDEN NAME FIRST Gladys MIDDLE Batty LAST Batty | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. 166-42-3991 | | | | | 17. INFORMANT Bettye E. Brown ADDRESS Hyattsville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds to abdomen (handgun) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30 PM 5-15-1980 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot by police. | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) blg. | | | | | 21f. LOCATION STREET 5233 Kenilworth Ave. CITY OR TOWN Prince George's COUNTY Md. STATE Md. | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | | | TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER | | | | | DATE SIGNED 5-16-80 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 5-20-80 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | | 23d. LOCATION CITY OR TOWN Arlington COUNTY Va. STATE Va. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Edward W. James Washington, D.C. NAME W.H. Bacon Funeral Home ADDRESS 3447-14th St., N.W. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1980 | | | | | 25b. REGISTRAR'S SIGNATURE Anthony M. Cherry | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13500 | |
|---|-------------------------|--|--|---|---|---|--|---|--|-------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Robert BRUCE, Jr. | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 5-21 1980 | | 2b. HOUR M | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4-2-25 | 6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS. | IF UNDER 1 YR. MONTHS DAYS 5-21 1980 | IF UNDER 24 HRS. HOURS MIN 5-21 1980 | 2c. DATE PRONOUNCED DEAD 5-21 1980 | | 2d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Chesley (DOA) | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY automotive | | | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Pr George | | 13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3417 Parkway Terrace Dr. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Bruce, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny McMillen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. -- | | 17. INFORMANT Doris Conner | | | | ADDRESS 5617 Auth Road Camp Springs, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5-22-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 24 May 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Funeral Home Inc | | | | 25a. DATE REC'D. BY REGISTRAR JUN 19 1980 | | | | 25b. REGISTRAR'S SIGNATURE Robert E. Wilhelm | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|---|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward D. BUMBRAY | | | 2b. DATE KNOWN OF DEATH ESTIMATED 5-1 19 80 | | | 2c. DATE PRONOUNCED DEAD 5-1 19 80 | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 3 DAY 31 YEAR 29 | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | IF UNDER 1 YR. MONTHS 5 DAYS 1 | IF UNDER 24 HRS. HOURS 1 MIN. | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prima Trece | | |
| 10. CITY OR TOWN OF DEATH Chesapeake | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) IRON WORKER | | |
| 13a. STATE D.C. | | | 13b. COUNTY WASHINGTON | | | 13c. INSIDE CITY LIMITS? YES NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST EARL MIDDLE BUMBRAY LAST FRANCIS | | | 15. MOTHER'S MAIDEN NAME FIRST FRANCIS MIDDLE GADDIS LAST GADDIS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | |
| 16b. SOCIAL SECURITY NO. 229-26-7820 | | | 17. INFORMANT Washington, D.C. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION 4-29-80 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Traumatic injuries | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR AM MONTH 4 DAY 29 YEAR 1980 P.M. 4-29-80 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell from scaffold | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) USSC Treatment Plant | | | 21f. LOCATION STREET 6101 Sandy Spring Rd. CITY OR TOWN Lanham COUNTY PGC STATE MD | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | TITLE (SPECIFY) Deputy | | | DATE SIGNED 5-2-80 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE MAY 6, 1980 | | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY | | |
| 24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. | | | ADDRESS 4339 HUNT PLACE, N.E. | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1980 | | |
| 25b. DATE REC'D. BY REGISTRAR MAY 5 1980 | | | 25c. SIGNATURE Augusto P. Rodriguez | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-333333)
FROM : SAC, NEW YORK (100-111111)
SUBJECT: [Illegible]
RE: [Illegible]

[Large block of illegible text, likely a memorandum or report body]

DATE: MAY 6, 1960
BY: [Illegible]
100-333333-1111

CERTIFICATE OF DEATH

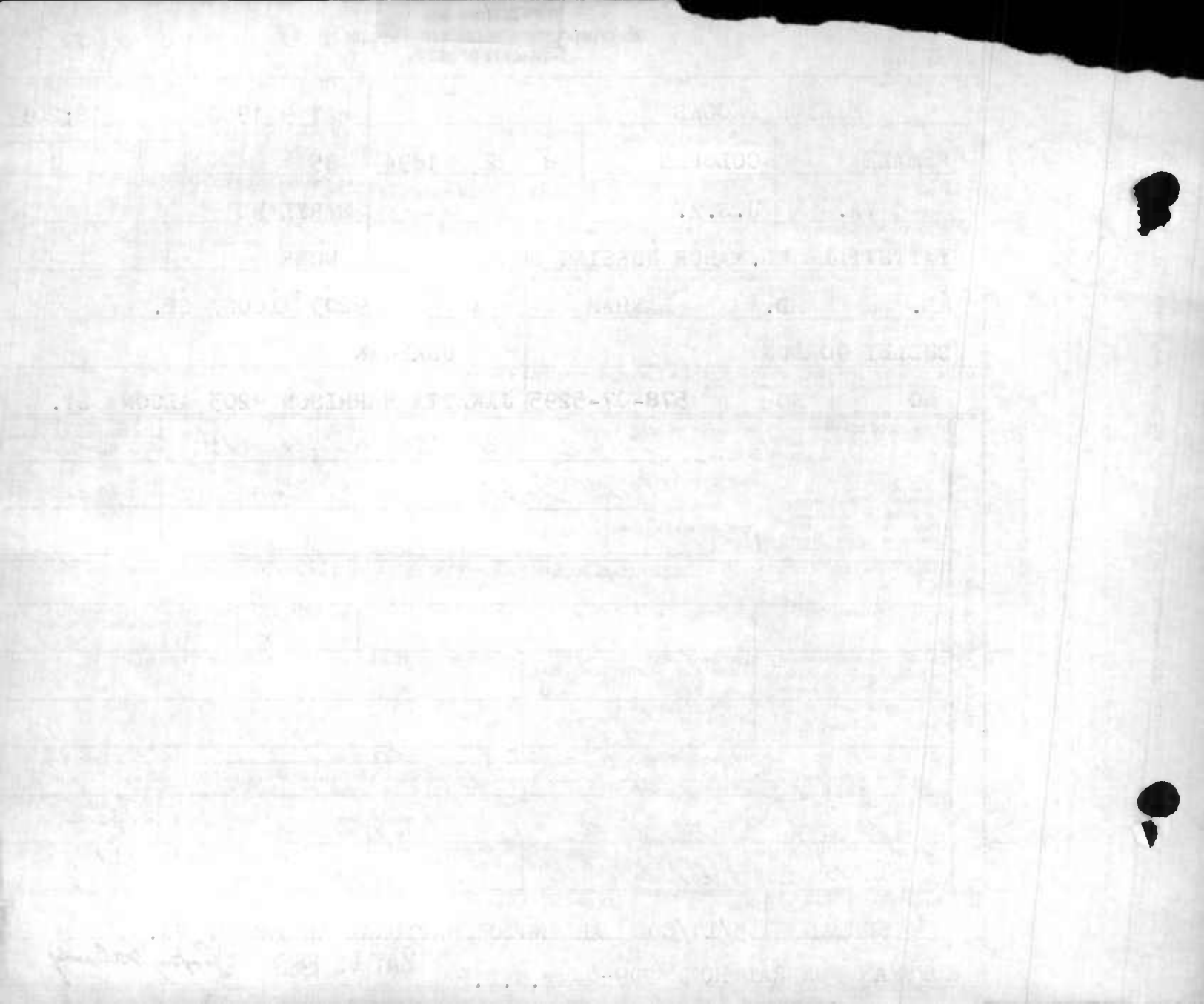
REG. NO.

| | | | | | |
|--|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) MARION BROOKS | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 9 1980 | | 2b. HOUR 8:20 PM | |
| 3 SEX FEMALE | 4 RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 8 2 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MARYLAND PG MD. | |
| 10. CITY OR TOWN OF DEATH HYATTSVILLE MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | 13b. COUNTY MD. PG | 13c. CITY OR TOWN LANHAM | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DUDLEY GORDON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-07-5295 | | 17. INFORMANT ADDRESS JANETTA HARRISON 9203 ALCONA ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Cerebral myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to, or as a consequence of, Degenerative Heart Disease DUE TO, OR AS A CONSEQUENCE OF Sym | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27/80 to 5/9/80 , that (I) (we) last saw the deceased alive on 5/9/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Myron L. Lenkin | | DEGREE | | 22c. DATE SIGNED 5/9/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN | | 22e. ADDRESS 2309 STOREFIELD RD WHEATON MD | | 22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/14/80 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL ARLINGTON VA. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOFFMAN FUNERAL HOME 909-6 ST. N.W. | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE Barry Halbrudy | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 6013503 | |
|---|--|---|--|--|--|---|--|--|--|---------------------|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE S. BUSH | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 31 80 | | 2b. HOUR 3:45 A M | | | |
| 3 SEX FEMALE | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 04 30 20 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS 60 | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md. | | 13c COUNTY Pr. George | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> Clinton | | 13e. STREET ADDRESS 7009 E. Clinton St. | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Leo Sedwick | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lona B. Grobe | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 291-22-3756 | | 17 INFORMANT ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pulmonary edema 4354 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) cardiomyopathy and coronary artery disease (c) Renal Insufficiency APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Arrhythmia with ventricular premature contractions | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/31 19 80 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE Clinton MD | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5/30 19 80 , to 5/31 19 80 , that (I) (we) lost saw the deceased alive on 5/31 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Thomas Y. Ko | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 5/31/80 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS Y. KO | | 22e ADDRESS 9131 Pascataway Rd Clinton, MD 20735 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b DATE 5/31/80 | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24 FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b REGISTRAR'S SIGNATURE John H. ... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8013504 | | | |
|--|--|---|--|--|--|---|--|---|--|---------------------|-----|--------------------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| CHESTER | | W. | | CARTER | | | | 05 | | 17 | 80 | 6:25P _M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | Black | | 2 MONTH 28 DAY 38 YEAR | | 42 | | MONTHS | | DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| 83 Virginia | | USA | | | | PRINCE GEORGE'S COUNTY | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 74 CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | None | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 35 Maryland | | Bladensburg | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6032 57th Avenue | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| 140 Chester W. Carter Sr. | | Mintie Tome | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | | | | |
| 1 No | | 230-50 6925 | | Sythenia J. Carter | | Same as 13e | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 385- | | Cardiac arrest | | | | 24h | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Hemorrhagic Shock | | | | 24h | | | | | | | |
| | | (c) Renal transplant nephrectomy | | | | 72h | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | Chronic Renal Failure, Hypertension | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 2 5/14 | | Chronic transplant Rejection | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 19 80 to 5/17 19 80, that (I) (we) last saw the deceased alive on 5/17 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| | | MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> | | 5/19/80 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| Steven M. Piliak | | 4700 AUTH PLACE, CAMP SPRINGS. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | |
| Burial | | 5/22/80 | | Harmony Memorial Park, Landover, Maryland | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 25 DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | |
| Johnson & Jenkins Inc. | | 716 Kennedy St., N. W. | | MAY 23 1980 | | | | | | | | | |



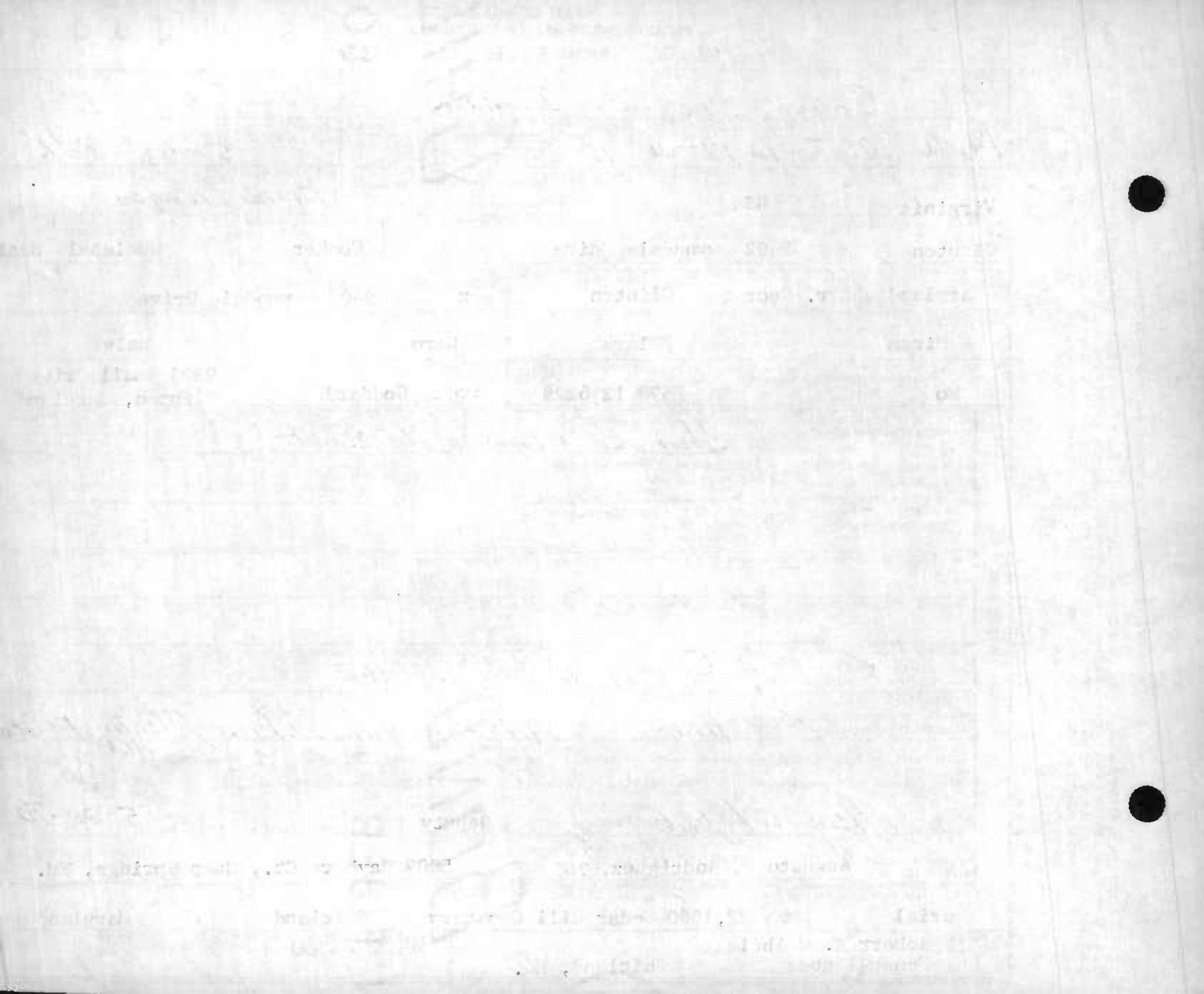
CHESTER W. CARTER
Jas. Jack
PRINCE GEORGE'S COUNTY
PRINCE GEORGE'S GENERAL HOSPITAL
5052 57th Avenue
Chester, Carter St.
200-50 57th Ave. Prince George's Co. Md.



Johnson & Johnson Inc. The Kennedy St.
200-50 57th Ave. Prince George's Co. Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1, 2, AND 3, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 0 1 3 5 0 5 | |
|--|--|----------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Coyal Andrew CLARK | | | | | | 2a. DATE OF DEATH KNOWN OF ESTI- MATED 5-19 1980 | | 2b. HOUR 12 | | 2c. DATE PRONOUNCED DEAD 5-19 1980 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12-17-08 71 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 71 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | |
| 10. CITY OR TOWN OF DEATH Clinton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9402 Gwynndale Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cooker | | 12b. KIND OF BUSINESS OR INDUSTRY Wholesale Meat | |
| 13a. STATE Maryland | | | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Clinton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9402 Gwynndale Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hiram Clark | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caro Hale | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578 12 6229 | | 17. INFORMANT Janice Goddard | | | | ADDRESS 9303 Small Drive Clinton, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot gun wound of the chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 9551 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:15 P.M. 3-19 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9402 Gwynndale Drive, Clinton, Pr. Geo. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5-20-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 22, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland | | 23e. DATE RECEIVED BY REGISTRAR MAY 27 1980 | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | ADDRESS Suitland, Md. | | | | 25a. REGISTRAR'S SIGNATURE [Signature] | | | |



Items 18, 21a-22a G547 9/4/80 dad STATE OF MARYLAND
 1- STATE REGISTRAR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 135061

| | | | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| JAIME | | Lynne | | CLARK | | | | 5 | | 25 | | 19 | | 80 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. TIME | |
| female | white | Nov. 16, 1979 | | 6 | | 9 | | | | 5 | | 25 | | 19 | | 80 | | P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | USA | | WIDOWED | | DIVORCED | | Prince George's County | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Cheverly | | Prince George's Hospital | | None | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | Prince George's | | Upper Marlboro | | YES | | 5103 Brimfield Drive | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| James | | L. Randall | | Jayne | | Elizabeth | | Linn | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | None | | Joe E. Linn | | Box 135, Mollusk, Va. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a): | | Fracture of skull | | | | | | | | | | | | | | | | | |
| 9682 | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b): | | | | | | | | | | | | | | | | | | | |
| (c): | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | YES | | NO | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | | | | | | | | | |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | struck in head | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | | | | | | |
| WHILE AT WORK | | home | | 5103 Brimfield Dr., Upper Marlboro, Md. | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy | | Inspection | | Inquiry | | and in my opinion | | | | | | | | | | | |
| death resulted from: | | Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | Assistant | | 5-26-80 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME | | ADDRESS | | | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | |
| Burial | | 5/28/1980 | | Bethel Un. Meth. Cemetery | | Lively | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| James C. Ash | | JUN 3 1980 | | Molly McCready | | | | | | | | | | | | | | | |

Perd. trichura¹⁴

A. Korell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 5 0 7 | |
|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE MARIE CLEM | | | 2a DATE OF DEATH MONTH DAY YEAR 05 08 80 | | 2b HOUR 6:15AM |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Dec. 29 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | |
| 10 CITY OR TOWN OF DEATH CHEVERLY MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. HOSP. & MED. CTR. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary U.S. Govt. | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland | | | 13c CITY OR TOWN St. Marys Leonardtown | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Theodore Gates | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Dyer | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) none | | 17 INFORMANT ADDRESS Edna W. Norris-niece-Ansonta, Conn. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon (metastatic)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1539</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/5</u> 19 <u>80</u> , to <u>5/8</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> 19 <u>80</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Bruce Lowman, M.D.</u> | | DEGREE | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE LOWMAN, M.D. | | 22e ADDRESS 5901 Medical Terrace, Chevy Chase, Md. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE May 13, 1980 | | 23c NAME OF CEMETERY OR CREMATORY Congressional | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | 24 PREPARED BY NAME Warner E. Humphrey, Inc. | | 25 DATE REC'D. BY REGISTRAR MAY 16 1980 | |
| 26 ADDRESS 8434 Ga. Ave., S.S. Md. | | 27 REGISTRAR'S SIGNATURE <u>Robert McCreedy</u> | | | |



PRINCE GEORGE COUNTY

CHEVERLY MD. PRINCE GEO. HOSP. & MED. CTR.

Charles E. White

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDGAR I. COOK | | | 2a. DATE OF DEATH MONTH DAY YEAR May 26, 1980 | | | 2b. HOUR 9.50 P_M | | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR May 21, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 87 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY School | | |
| 13a. STATE Maryland | | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN New Carrollton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8120 Powhatan Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rodney E. Cook | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Myers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1 | | 17. INFORMANT Raymond F. Cook | | 17a. ADDRESS 6114 83rd Avenue Riverdale, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS 5324 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) REJAL FAILURE - BLEEDING DUOD ULCER | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/24/80 - 5/13/80 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING ULCER - ABSCESS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/24 , 19 80 , to 5/26 , 19 80 , that (I) (we) lost saw the deceased alive on 5-26 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Barry Epstein | | | | | DEGREE MD | | 22c. DATE SIGNED 5/27/80 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY EPSTEIN, M.D. | | | | | 22f. ADDRESS 6201 Greenbelt Rd., College Pk, Md. 20740 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | | | |
| 24. NAME OF FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A. | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| 24a. ADDRESS Hyattsville, Maryland | | | | | | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13509

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|-----------------------------|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Lillie M. Cooper</i> | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>5-3 1980</i> | | | 2b. HOUR <i>M</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH <i>11</i> DAY <i>05</i> YEAR <i>05</i> | 6. AGE (IN YEARS) LAST BIRTHDAY <i>74</i> YRS. | IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i> | IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i> | 2c. DATE PRONOUNCED DEAD MONTH <i>5</i> DAY <i>3</i> YEAR <i>1980</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i> |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE <i>MD</i> | 13b. COUNTY <i>P. G.</i> | 13c. CITY OR TOWN <i>Scottdale</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>4303 Addison Rd.</i> | | |
| 14. FATHER'S NAME FIRST <i>William</i> MIDDLE <i>Ricks</i> LAST <i>Ricks</i> | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Lillie M.</i> MIDDLE <i>Sanders</i> LAST <i>Sanders</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>577-36-7355</i> | | 17. INFORMANT NAME <i>John H. Cooper</i> ADDRESS <i>Same as 13e</i> | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arteriosclerotic cardiovascular disease</i> 2507 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2507</i> |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | |
|--|--|---|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Augusta P. Rodriguez* M.D. *Deputy* MEDICAL EXAMINER DATE SIGNED *5-4-80*

EXAMINER'S NAME (TYPE OR PRINT) *Augusta P. Rodriguez* ADDRESS *5009 Rayburn Court, Camp Springs*

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE <i>5-10-80</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cem</i> | 23d. LOCATION CITY OR TOWN <i>Highland Pk. Md</i> COUNTY <i>1 Md 20031</i> STATE <i>Md</i> |
| 24. FUNERAL DIRECTOR NAME <i>H.S. Washington</i> ADDRESS <i>4925 Nyanza H. Bonnoeghs Ave</i> | | 25a. DIED BY <i>MAY 15 1980</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13510

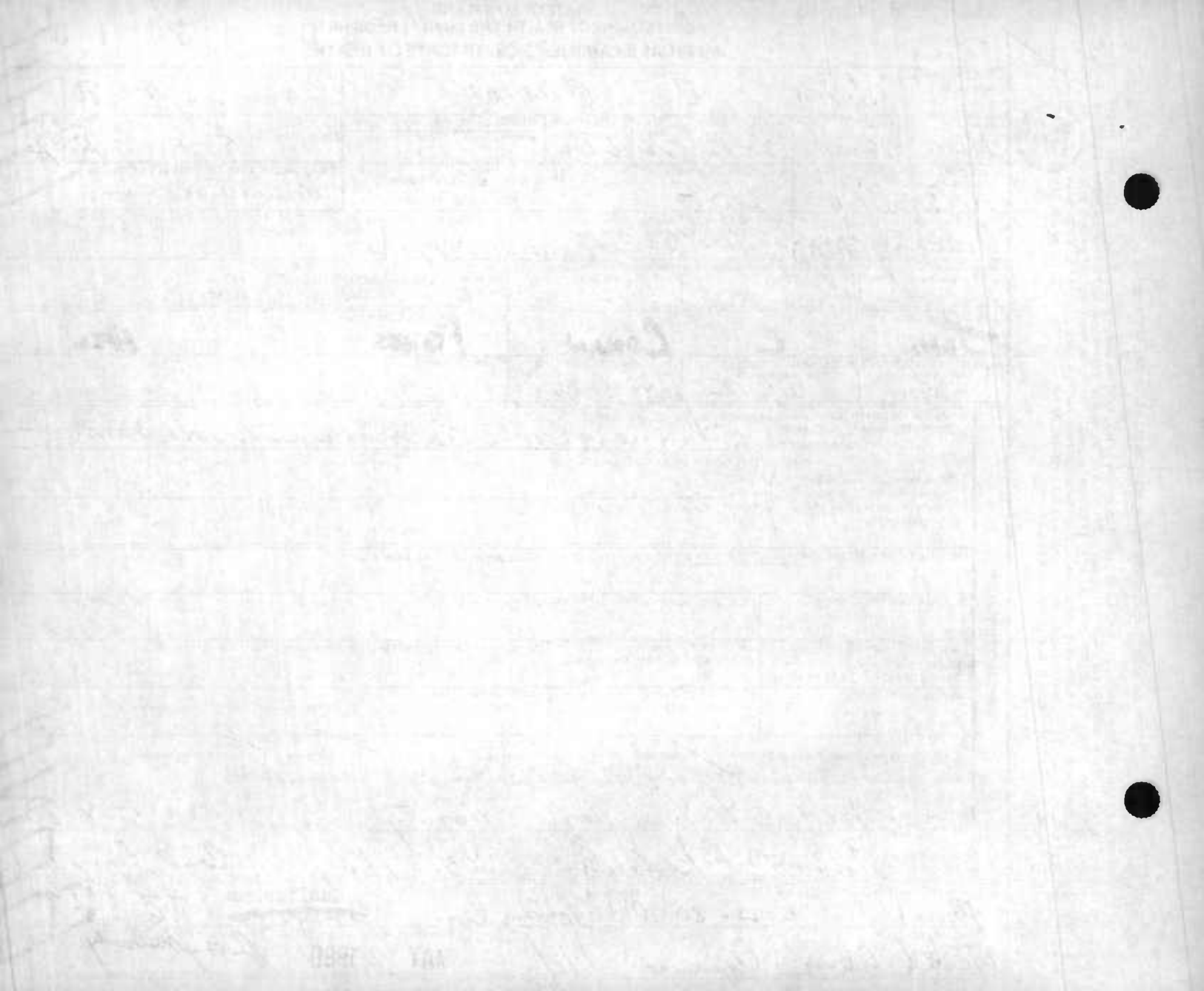
| | | | | | | | |
|--|-------------------------|--|---|---|--|--|---------------|
| 1. DECEASED NAME (TYPE OR PRINT) John C COWAN | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-8 1980 | | | 2b. HOUR M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 2-12-20 60 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 60 | IF UNDER 1 YR. MONTHS DAYS 5-8 | IF UNDER 24 HRS. HOURS MIN. 5-8 | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-8 1980 | 2d. HOUR M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Chesley | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr. Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE MARYLAND | | 13b. COUNTY PRINCE GEORGE | | 13c. CITY OR TOWN BRANDYWINE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John C COWAN | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST AGNES HALL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II | | 16b. SOCIAL SECURITY NO. 242-10-0693 | |
| 17. INFORMANT ADDRESS LULA B COWAN 14310 BRANDYWINE RD. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningeal & cerebral vascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 5-8-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez | | ADDRESS 5009 Rayburn Court Langley Park P.G. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-13-80 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cen. | | 23d. LOCATION Brandywine P.G. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Marcel Adams Aguirre Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE Barry Halbury | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE CALCULATE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

0000



BP

DHMH - 17
(VR A15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3511

| | | | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|--|--|--------|--|------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 26. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH | | DAY | | YEAR | | 27. HOUR | |
| Edward Everett COX | | | | | | | | 5-13 | | 1980 | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 28. DATE PRONOUNCED | | MONTH | | DAY | | YEAR | | 29. HOUR | |
| Male | Black | 3-14-14 | | 66 | | | | | | 5-13 | | 1980 | | | | | | 11:45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | USA | | WIDOWED | | DIVORCED | | Prince Georges | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Chesley | | Princess Georges General Hospital | | RETIRED | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| DISTRICT of Columbia | | WASH | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1701-16th St. N.W. | | | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | |
| Everett Cox | | | | | | | | Homer Cox | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| yes | | 235-09-2579 | | MRS Adena Cross-DAUGHTER | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 4029 | | Hypertension cardiovascular disease | | | | | | | | | | | | | | | | | |
| | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | Alcoholism | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | | | | | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | Augusto P. Rodriguez | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED | | 5-13-80 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Augusto P. Rodriguez M.D. | | ADDRESS | | 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATION | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| Burial | | 5/17/80 | | Lincoln Memorial Cemetery | | Suitland, Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | John H. Stewart | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Stewart Funeral Home-4001 Benning Road, | | | | NE. MAY 23 1980 | | [Signature] | | | | | | | | | | | | | |

STATE OF NEW YORK
COMMISSIONER OF HEALTH
ALBANY, N.Y.

REPORT OF THE COMMISSIONER OF HEALTH
ON THE STATE OF THE HEALTH OF THE PEOPLE OF THE STATE OF NEW YORK
FOR THE YEAR 1900

ALBANY, N.Y.: JAMES B. LEECH, STATE PRINTER.
1901.

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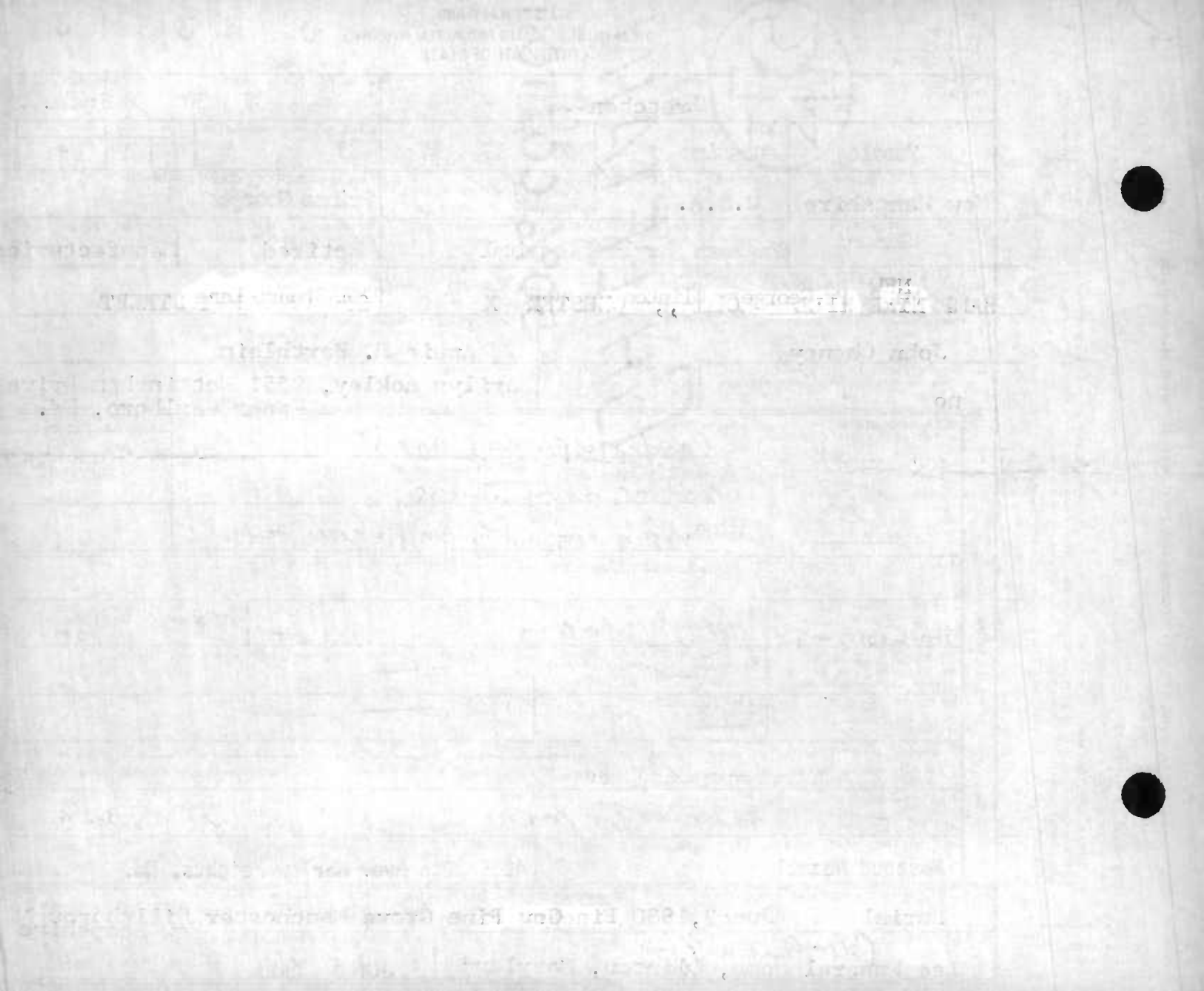
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 13512 | | | |
|---|--|--------------------------------|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Glenn K. CROSMAN | | | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 5-7-80 | | 7b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3-27-96 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 84 | | IF UNDER 1 YR. MONTHS DAYS 84 | | IF UNDER 24 HRS. HOURS MIN. 84 | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-9-80 | | 24. HOUR P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. D.C. Gov't | | | | 12b. KIND OF BUSINESS OR INDUSTRY Carpenter | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Avondale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2013 - Brighton Rd. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Crosman | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice (Unknown) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 17. INFORMANT Ruth A. Dinkins | | | | ADDRESS 8217-Briar Creek Annandale, Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | Va. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-9-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. | | | | ADDRESS Mt. Rainier, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1980 | | | | 25b. REGISTRAR'S SIGNATURE Henry McBrady | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--------------------|---|-------------------|---|-------------|---|------------|----------------------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST EMMA | MIDDLE Gretchen | LAST CURTIS | 2a. DATE OF DEATH | | MONTH 05 | DAY 30 | YEAR 80 | 2b. HOUR 8:45A.M. |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH 06 TH 17 ^{YR} 94 ^{AR} | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Manufacturing | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE NEW HAMPSHIRE | | 13b. COUNTY HILLSBOROUGH | | 13c. CITY OR TOWN MANCHESTER | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 259 CHESTNUT STREET | | | | |
| 14. FATHER'S NAME FIRST John Cheney | | | | 15. MOTHER'S MAIDEN NAME FIRST Annie M. Barthleim | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 022 05 8684 | | 17. INFORMANT ADDRESS Marilyn Ackley, 9551 Nottingham Drive Upper Marlboro, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiac arrhythmias</u> (c) <u>Respiratory and Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION 5-30-80 Tracheostomy. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory failure. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>5-30-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Emmett</u> MD. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5-30-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Massoud Nemati | | | | 22e. ADDRESS 4235 28th Ave. Marlow Heights, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE June 2, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove | | 23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Hillsborough New Hampshire | | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Clinton, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Kristy McCreedy</u> | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13514 | | | | | | | | | |
|---|--|----------------------|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|----------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert A. Davidson | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-29-80 | | | | | | | | | | 2b. HOUR 4:15 M A | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-19-27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 5-29-80 | | MONTH DAY YEAR | | HOUR MIN. | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Chesley | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital (over) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Botany Professor | | | | 12b. KIND OF BUSINESS OR INDUSTRY Education | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. CITY OR TOWN Prince George | | 13c. CITY OR TOWN Cheverly | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5808 Dewey Street | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Davidson | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Neubold | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | IF YES, GIVE WAR OR DATES 1957-1959 | | 16b. SOCIAL SECURITY NO. 480-24-0825 | | | | 17. INFORMANT (Wife) Phyllis Davidson | | | | ADDRESS Same As #13 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cerebral vascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-29-80 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez | | | | ADDRESS 5209 Rayburn Court, Camp Springs, Md 20731 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE June 3, 1980 | | | | 23c. NAME OF CEMETERY OR CREMATORY Midway Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE London Mills, Illinois | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | ADDRESS 11800 N. H. Ave. Silver Spring, Md. | | | | 25a. JUN 3 1980 | | | | 25b. REGISTERAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST DANIEL | | MIDDLE DAVIS | | LAST DAVIS | | 2a. DATE OF DEATH MONTH DAY YEAR 5. 14. 80 | | 2b. HOUR 9.45 A.M. | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Africa | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. GEN. HOSP. ECF | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister | | 12b. KIND OF BUSINESS OR INDUSTRY Ministry | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Fairmount Heights | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Jesse Dean-5904 Jay St. Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Senility 2500 DUE TO, OR AS A CONSEQUENCE OF (b) ② Hypoglycemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5.5.80 to 5.14.80 , that (I) (we) last saw the deceased alive on 5.14.80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H. A. Molavi. M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5.14.80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. MOLAVI. M.D. | | | | | | 22e. ADDRESS 6005 Landover Rd Cheverly Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-20-80 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Nat'l. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Beltsville Md | | | |
| 24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS | | | | | | ADDRESS 4925 BURROUGHS AVE N.E. | | 25. DATE REC'D. BY REGISTRAR MAY 21 1980 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Patricia McBratney | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 of 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 0 1 3 5 1 6 | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|-----------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Jerry Lee Davis | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 26 1980 | | 2b. HOUR M | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1965 | | 6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 26 1980 | | 2d. HOUR 9:25P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Prince Geo. | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS 7705 Frederick Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara J. Davis | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220 90 6174 | | | | 17. INFORMANT ADDRESS Barbara J. Gowen Same as #13 (Mother) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:08PM 5/26/80 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Bladensburg Marina | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bladensburg Marina, Bladensburg, PrinceGeo, MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H R Guard</i> | | | | TITLE (SPECIFY) Assistant | | | | M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 5/27/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard M.D. | | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/30/80 | | | | 23c. NAME OF CEMETERY Washington National | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Geo. Md. | | | |
| FUNERAL DIRECTOR NAME Frank's Gasch's Sons Funeral Home, P.A. | | | | ADDRESS Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | | | 25b. REGISTRAR'S SIGNATURE <i>Wm J. McCreedy</i> | | | |

MEDICAL CERTIFICATION

NOV 22 1964

Washington, D.C.

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: [illegible]

Very truly yours,

[illegible signature]

[illegible title]

[illegible address]

[illegible address]

[illegible address]

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ITEMS 7a, 7b g544 6/13/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 5 1 7
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) EUGENE DEAL | | 2a. DATE OF DEATH MONTH DAY YEAR 04 26 80 | |
| 3 SEX M | | 2b. HOUR 8:20 AM | |
| 4 RACE N | | 5. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | |
| 5. DATE OF BIRTH MONTH DAY YEAR Oct 13 1913 | | 6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY West Bend Co | |
| 13a. STATE MD | | 13b. COUNTY P.G. | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 9029 Volth st. | | 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Deal | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Fletcher | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 42W 2 | | 17. INFORMANT ADDRESS Ruth Deal Same as 13 E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>For advanced arteriosclerotic heart</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>disease with terminal (cardiac) onset</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>several years</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Severe chronic obstructive pulmonary disease.</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/26</u> 19 <u>80</u> to <u>4/26</u> 19 <u>80</u> , that (I) (we) saw the deceased alive on <u>4/26</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Frederick Henry Wilhelm MD</u> | | 22c. DATE SIGNED <u>4/26/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK WILHELM | | 22e. ADDRESS 5807 ANNAPOLIS RD HYATTSVILLE MD 20784 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 5-2-1980 | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville Prince Georges | |
| 24. FUNERAL DIRECTOR NAME H.S. Washington | | 25a. DATE REC'D BY REGISTRAR 4925 | |
| 25b. REGISTRAR'S SIGNATURE Bouroughs Ave N.E. | | 25c. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHENERY

Tested from

FREDERICK WILHELM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 3 5 1 8 | | | | | |
|---|--|--|---|--|--|--|--|--|--------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| MARION F. RAMIREZ ^{de} E ARELLANO | | | | | MAY 15 1980 | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| MALE | | WHITE | | AUGUST 5 1913 | | 66 YRS. | | 1:00A M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| PUERTO RICO | | U.S.A. | | | | PRINCE GEORGES COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ANDREWS AFB | | MALCOLM GROW USAF MEDICAL CENTER | | | | U.S. NAVY | | MILITARY | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| D.C. | | | | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2584 NAYLOR ROAD APT 303 | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | | |
| RAFAEL WILLIAM RAMIREZ ^{de} E ARELLANO | | | | | LUCILLE JOSEPHINE KIMERER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | |
| YES | | | 1933 | | 561-54-2171 | | THOMAS RAMIREZ ^{de} E ARELLANO (S) 205 WEST CRAIG SAN ANTONIO, TX | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> | | | | | | | | | | |
| 410- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>EXTENSIVE ANTERIOR MI</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) <u>CARDIOGENIC SHOCK</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | 21g. CITY OR TOWN | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | STREET | | COUNTY STATE | | |
| 22 I certify that (this hospital) attended the deceased from <u>15 MAY</u> 19 <u>80</u> to <u>15 MAY</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>15 MAY</u> 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| <i>Rolando B. Cadiz</i> | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 15 MAY 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| ROLANDO B. CADIZ, MAJ, USAF, MC | | | | | MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | 5-23-80 | | Arlington Natl. | | Arlington, Virginia | | | | |
| 24 FUNERAL DIRECTOR'S NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robt E Wilhelm | | | | | 4308 Suitland Rd., Suitland, Md. | | MAY 27 1980 | | | |

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

13

John D. Rockefeller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 5 1 9 | |
|---|---|--|---|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) DANIEL MAURICE DENNEY | | 2a. DATE OF DEATH MONTH DAY YEAR May 29, 1980 | | 2b. HOUR 1:14P M | |
| 3 SEX Male | 4 RACE Caucasian | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 25 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD | |
| 10. CITY OR TOWN OF DEATH Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | 13c. COUNTY P.G. | 13d. CITY OR TOWN Lanham | 13e. STREET ADDRESS 9922 Lanham-Severn Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Robert Denney | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della ----- McQuaid | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 290-03-2354 | | 17. INFORMANT ADDRESS Carmen Denney Same as #13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>astrotoma grade IV</u> 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 20 1979</u> to <u>May 29 1980</u> , that (I) (we) lost saw the deceased alive on <u>Mar 29 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>5/30/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. HAIDAK MD</u> | | 22e. ADDRESS <u>Belmont Rd Hyattsville</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 31 May 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens | |
| 23d. LOCATION CITY OR TOWN Davidsonville | | COUNTY P.G. | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Beall F.H. | | ADDRESS 9013 Annapolis Rd. Lanham, Md. | | 25a. DATE RECEIVED BY REGISTRAR JUN 10 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

• • •



| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13520 | | | |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS R. DIAMOND | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH May DAY 27 YEAR 1980 | | 2b. HOUR 4P | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH (MONTH DAY YEAR) July 19, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS U.S. GOVERNMENT | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4206 Underwood Street | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Andrew J. Diamond | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Rose A. Murray | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579 10 1700 | | 17. INFORMANT Jean E. Diamond | | | | ADDRESS Same as #13 (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease with 496- DUE TO, OR AS A CONSEQUENCE OF cor pulmonale Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Heart trauma in auto accident, arteriosclerosis | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4-27 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto accident | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) Street | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) PGCH Drive, Cheverly, P. Georges, Md | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez, M.D. (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 5/29/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Court Camp Springs, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/31/80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) Brentwood P.G. Md. | | | |
| 24. FUNERAL DIRECTOR (NAME AND ADDRESS) Francis Gasch's Sons Funeral Home, P.O. Hyattsville, Maryland | | | | | | | | | | 25a. DAY BY REG JUN 3 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part A may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHHM-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 0 | 1 | 3 | 5 | 2 | 1 | | | |
|---|--|--|--|--|--|--|--|--|--|--|---|---|---|---|---|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>James F. Dibrell</u> | | | | | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 3 SEX <u>M</u> | | | | | | | | | | 4 RACE <u>White</u> | | 5 DATE OF BIRTH | | MONTH | | DAY | | YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Texas</u> | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince Georges County</u> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH <u>Forestville</u> | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Regency Nursing Home</u> | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Engineer</u> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Dept Defense</u> | | | | | | | | | |
| 13a. STATE <u>Maryland</u> | | | | | | | | | | 13b. COUNTY <u>Pr Geo</u> | | 13c. CITY OR TOWN <u>Suitland</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>4704 Old Soper Road</u> | | | |
| 14 FATHER'S NAME FIRST <u>James</u> MIDDLE <u>F.</u> LAST <u>Dibrell, Sr</u> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Eugenia</u> MIDDLE <u>Greenwood</u> LAST <u>Greenwood</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> | | | | | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WWII</u> | | 17 INFORMANT <u>Alice M. Dibrell</u> | | ADDRESS <u>Same as #13</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | | | | | | | | | | | | |
| 4273 | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>79</u> , to <u>May 24</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED <u>6-1-80</u> | | | | | | | | | |
| 22b. SIGNATURE <u>Wm. Furst</u> | | | | | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm. Furst Md</u> | | | | | | | | | | 22e. ADDRESS <u>9401 Indiana Hwy Glen Hill</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | | | | | | | | | 23b. DATE <u>2 June 1980</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 23d. LOCATION CITY OR TOWN <u>Suitland</u> COUNTY <u>PG</u> STATE <u>Md</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Robert E. Wilhelm</u> ADDRESS <u>Funeral Home Inc</u> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUN 4 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

1890

May 1st

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Your obedient servant,

Wm. T. Smith

Secretary

to the Board of Directors

of the

City of New York

and

County of New York

and

State of New York

and

County of New York

and

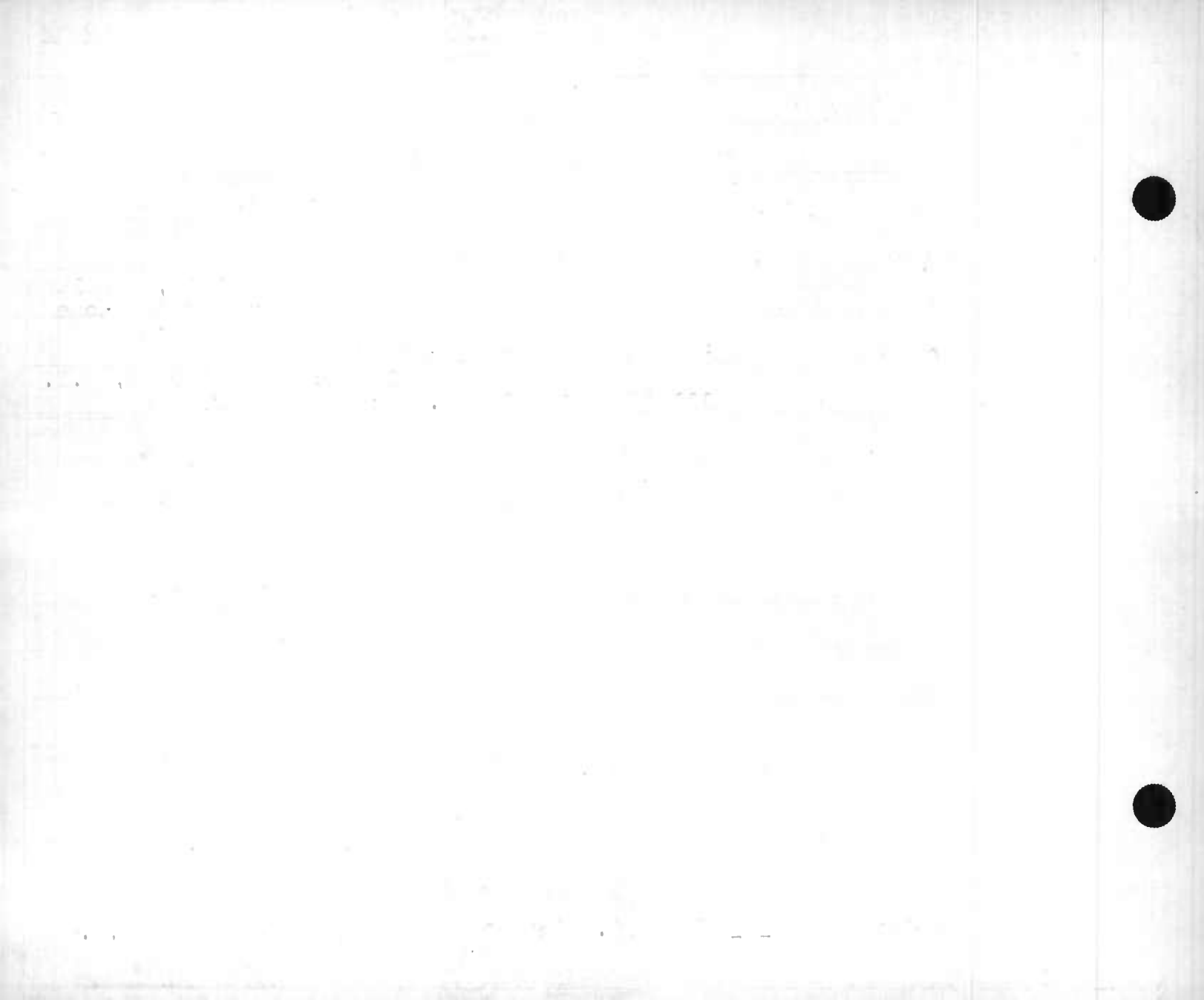
State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 5 2 2 | | | |
|--|--|---|--|--|--|---|--|
| FOR 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Philip</u> <u>Dillon</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>05. 01 - 80</u> | | 2b. HOUR <u>9:50p</u> M | |
| 3. SEX <u>M.</u> | | 4. RACE <u>B</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>06. 05 - 84</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>95</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Jamaica, WI</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Maryland PG</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Adelphi</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Manor Care, Adelphi</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <u>P.G</u> | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS <u>Adelphi, Maryland Manor Care Nursing Home</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>George</u> <u>Dillon</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Johanna Lawrence</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Unk</u> | | 16b. SOCIAL SECURITY NO. <u>111 05 4703</u> | | 17. INFORMANT # <u>15</u> ADDRESS <u>Tuckerman Street, N.E.</u> <u>Helen E. Mack (Daughter)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordic respiratory failure</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Atherosclerosis</u> (c) <u>Due to, or as a consequence of</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>days</u> <u>year</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Pneumonia - Decubiti ulcers - Joint contracture - Stroke syndrome</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 12</u> , 19 <u>80</u> , to <u>May 1st</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Hugo G. Graziani</u> DEGREE <u>MD</u> | | | | 22c. DATE SIGNED <u>5-1-80</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hugo G. Graziani</u> | |
| 22e. ADDRESS <u>800 Porshing Dr, 303A Silver Spring, Md. 20910.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5-7-80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Long Island City N.Y.</u> | |
| 24. FUNERAL DIRECTOR <u>Johnson + Jenkins</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 8 1980</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>H. G. Graziani</u> | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|--|---------|------------------|---|----------------|------------------|--|--|--|--------------------------------------|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| Guilio Di Michele | | | | | | 5-16 | | | 1980 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| Male | White | 4-01-06 | 74 YRS. | | | 5-17 | | | 1980 | | | 319 M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| ITALY | | | U.S.A. | | | | | | Prince Georges | | | MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| CHEVERLY | | | PRINCE GEORGES GENERAL HOSPITAL | | | BRICK LAYER | | | CONSTRUCT. | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| MARYLAND | | | PRINCE GEORGES | | | HYATTSVILLE | | | XXX NO <input type="checkbox"/> | | | 5905 SARGENT ROAD | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | | | |
| CRISTINO | | | | | | D'MICHELE | | | | | | MARIA ANGELSANTÉ | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| NO | | | | | | 579-05-0018 | | | MARY D'MICHELE | | | SAME AS 13 WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>White sclerotic Cardiovascular disease</u> | | | | | | | | | | | | | | |
| 4292 | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | |
| <u>Pruntho grave pneumonia with effusion</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| | | | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | |
| | | | | | | | | | | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> | | | | | | TITLE (SPECIFY) Deputy | | | | | | DATE SIGNED 5-17-80 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| BURIAL | | | | | | 5/21/80 | | | GATE OF HEAVEN | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | | | | | SILVER SPRING MONT MD. | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | | | | | MAY 19 1980 | | | | | | <u>History McCreedy</u> | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 5 2 4
CERTIFICATE OF DEATH

| | | | | | | | |
|--|---------|---|--|---|------|--|----------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | LAST | | |
| Georgett O. Dodson | | May | | 28 | 1980 | | 2:30 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | | 59 | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Wash., D.C. | | USA | | | | Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | P. G. General Hospital | | Driver | | Delivery | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | PG | | Capt. Hgts | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | No | | Unknown | |
| Johnson | | King | | 17. INFORMANT | | ADDRESS | |
| | | Virginia | | Thomas W. Dodson, Son, Same as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DO TO, OR AS A CONSEQUENCE OF (b) <u>Heart crvif</u> DO TO, OR AS A CONSEQUENCE OF (c) <u>myeloma</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/2/79, to 5/28/80, that (I) (we) lost saw the deceased alive on 5/28/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| Dr. Lewis H. Dennis | | 831 Univ. Blvd. E., Silver Spring, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5-31-80 | | Wash. Natl. Cem. | | Suitland, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robt E Wilhelm | | 4308 Suitland Rd., Suitland, Md. | | 5/31/80 | | | |

MEDICAL CERTIFICATION

2202 BP



[Faint, illegible handwritten text]



FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8013525

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM F. DONALDSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-03-80 | | | 2b. HOUR 4:30AM | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH DAY MONTH YEAR Sept. 27 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Griffith Consum. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Ricketts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-05-0114A | | 17 INFORMANT ADDRESS Mary E. Donaldson same as 13c | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest of unknown etiology</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-24-1980</u> to <u>5-3-1980</u> , that (I) (we) lost saw the deceased alive on <u>5-3-1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Mukesh Lohar MD</u> | | | DEGREE | | | | 22c. DATE SIGNED 5/3/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mukesh Lohar | | | 22e. ADDRESS Prince George General Hosp. Cheverly, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 6, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | |
| 24 FUNERAL DIRECTOR NAME Beall Funeral Home 16000 Annapolis Rd Bowie Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Patricia McCready</u> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 5 2 6

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FLORENCE C. DUMM | | | 2a. DATE OF DEATH MONTH DAY YEAR May 27, 1980 | | 2b. HOUR 11:20a |
| 3 SEX FEMALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 12, 1899 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | |
| 10 CITY OR TOWN OF DEATH RIVERDALE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EUGENE LELAND MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME |
| 13a. STATE Maryland | | | 13b. COUNTY Prince Geo. | 13c. CITY OR TOWN Riverdale | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Henry Stemmer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Axmaker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 716 05 5413B | | 17 INFORMANT ADDRESS Mary E. Talbot Same as #13 (Daughter) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO OR AS A CONSEQUENCE OF acute pulmonary thromboembolism DUE TO OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetic mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19 19 80 to 5/27 19 80 , that (I) (we) last saw the deceased alive on 5/19 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J. Richard Lilly, M.D. | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/28/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Richard Lilly, M.D. | | 22e. ADDRESS 5804 Baltimore Ave. Hyattsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/31/80 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Altoona | | 23e. DATE REC'D. BY REGISTRAR JUN 2 1980 | | | |
| 23f. REGISTRAR'S SIGNATURE John J. Kelly | | 23g. REGISTRAR'S SIGNATURE | | | |

Medical Examiner notified and approved

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

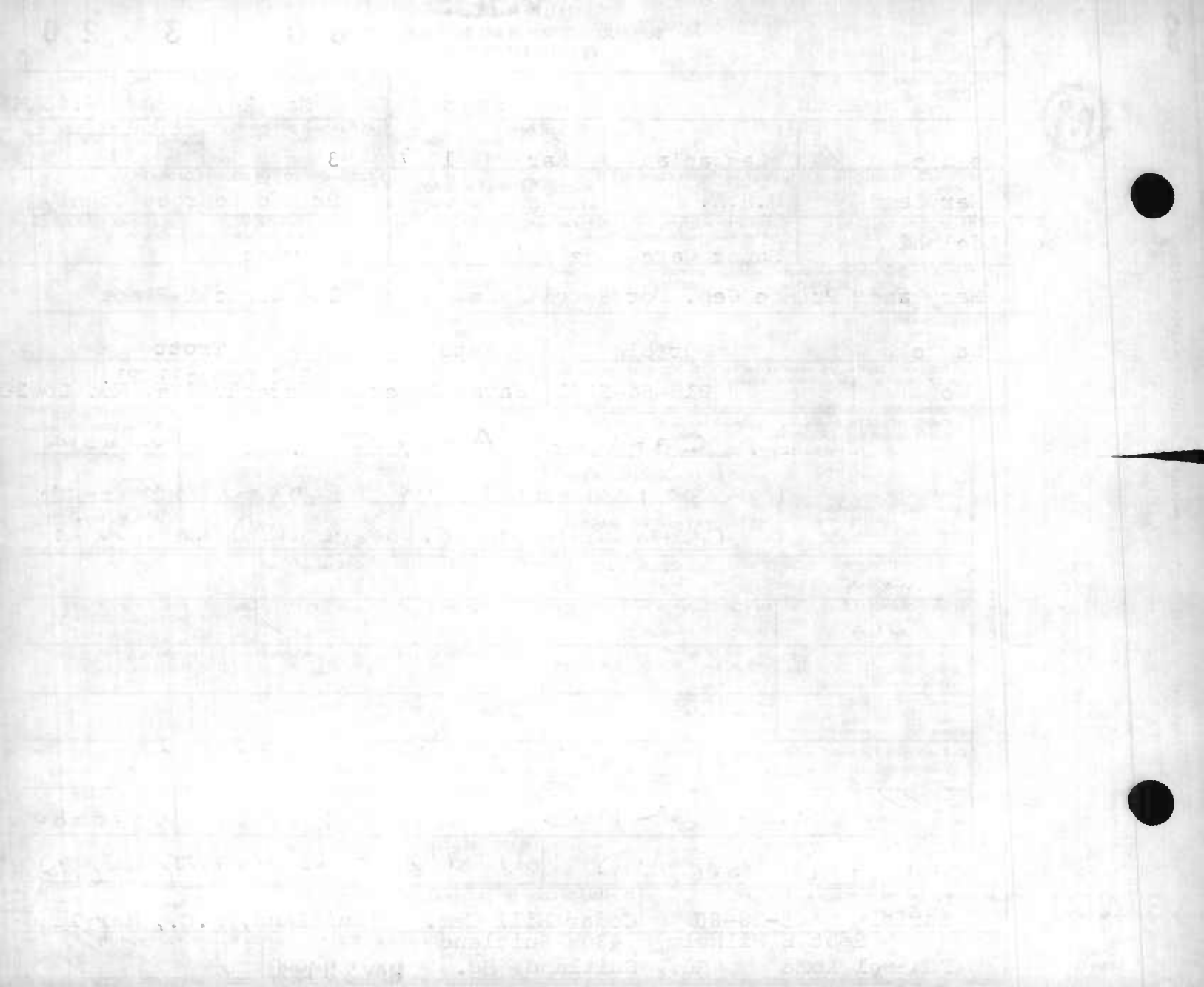
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 5 2 7 | | | |
|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NETTIE M DYSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 19 80 | | 2b. HOUR @:20P.M. | | |
| 3. SEX Female | 4. RACE Caucasian Black | 5. DATE OF BIRTH MONTH DAY YEAR 02 19 91 | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | |
| 10. CITY OR TOWN OF DEATH Minton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Pr. Georges Mitchelville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3800 Lotsford Vista Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Edwards | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Harris | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 05 2384D | | 17. INFORMANT ADDRESS Mrs. Regina Spears-niece-1811 61st Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Guan hypostive Septicemia</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Necrotic Decubitus Ulcer.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Concussive respiratory arrest</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Involuntarily</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION <u>4-14-80</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spontaneous head injury</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-29</u> 19 <u>80</u> , to <u>5-19</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5-18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>5-19-80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CIRIO. D. Montanez - MD</u> | | 22e. ADDRESS <u>3308 Dodge PK, Rd - Landover, MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE <u>May 24, 1980</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>Stewart Funeral Home</u> | | 24b. ADDRESS <u>4001 Benning Road</u> | | 25a. DATE REC'D. BY REGISTRAR <u>NE. MAY 28 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 70 0 1 3 5 2 8 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GRACE Eagen | | | | 2. DATE OF DEATH MONTH DAY YEAR May 26, 1980 | | | | 2b. HOUR 6:45AM | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR Mar 6 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD | | | |
| 10 CITY OR TOWN OF DEATH Adelphi | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care- Adelphi | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Prince Georges | | 13c. INSIDE CITY LIMITS? YES NO <input type="checkbox"/> | | 13d. STREET ADDRESS 7204 Donnell Place | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Samuel Norfolk | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Trott | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215-54-5063 | | 17 INFORMANT ADDRESS 7204 Donnell Pl, Sarah Roberts Forrestville, Md. 20028 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes many years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) none | | | | | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20, 1980, to 5-26, 1980, that (I) (we) last saw the deceased alive on 5-17, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Paul A DeVore M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-26-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A DEVORE, M.D. | | | | 22e. ADDRESS 6525 BELCREST RD HYATTSVILLE, MD 20885 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-28-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Robt E Wilhelm | | | | 24b. ADDRESS 4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 29 1980 | | 25b. REGISTRAR'S SIGNATURE R. J. Brady | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|--|---|---|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Olive C. Elliott | | | 2a DATE OF DEATH MONTH DAY YEAR May 25, 1980 | | | 2b HOUR 2:30 A.M. | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | |
| 10 CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Clerk | | 12b KIND OF BUSINESS OR INDUSTRY Mobile Park | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | 13b COUNTY Anne Arundel | | | 13c CITY OR TOWN Laurel | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Crawford | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Fraser | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | | |
| 16b SOCIAL SECURITY NO. 220-40-5892 | | | 17 INFORMANT 14005 Cove La Apt. 104 Mr. Shirley T. Elliott Jr. Rockville, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Pulmonary Embolism 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Congestive Heart Failure (c) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): Biased Pleural Effusion - already resolved | | | | | | | | | | |
| 19a DATE OF OPERATION N/A | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT OR INJURY OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30 P.M. May 25 1980 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE 3450 Ft Meade Rd Laurel Md 20810 | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-25-80 to 5-25-80 , that (I) (we) last saw the deceased alive on 5-25-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Mariano MD | | | | | | DEGREE MD | | | 22c. DATE SIGNED 5-25-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. JON C MARIANO MD | | | | | | 22e ADDRESS 3450 Ft Meade Rd Laurel Md 20810 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5/28/80 | | 23c NAME OF CEMETERY OR CREMATORY Mt. Moriah Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Boston, Nelson, Ky. | | | |
| 24 FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



MARY

EVANS

02-03-80

3.00P

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

02-03-80

02-03-80

02-03-80

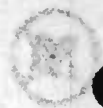
02-03-80

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 0 1 3 5 3 1 REG. NO. | |
|---|---|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) BRETTE DOUGLAS EVERS | | | 2a DATE OF DEATH MONTH DAY YEAR May 10, 1980 | | 2b HOUR P M 2.00 P M |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1903 | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD | | |
| 10 CITY OR TOWN OF DEATH Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b KIND OF BUSINESS OR INDUSTRY Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | | 13b COUNTY P.G. | 13c CITY OR TOWN Riverdale | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Harmon | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Horn | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO 579-16-3789-B | 17 INFORMANT ADDRESS 6003 Sarvis Ave. Riverdale, Md. William H. Evers | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 2300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Atherosclerosis</u> (c) <u>Diabetes Mellitus</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days Unknown Unknown |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/10/80</u> to <u>5/10/80</u> , that (I) (we) lost saw the deceased alive on <u>5/10/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death, so state.) | | | | | |
| 22b SIGNATURE <u>James Jaffe</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 5/11/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES JAFFE, M.D. | | 22e ADDRESS 5711 SARVIS AVE Riverdale, MD 20840 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 5-13-80 | 23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md. | |
| 24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | 25a RECEIVED BY REGISTRAR MAY 13 1980 | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 70 13533 | |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Walter H. FEDERN</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-4-80 | | | | | | | | | | 2b. HOUR 12 | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3-1-10</i> | | 6. AGE (IN YEARS) (LAST BIRTHDAY) <i>70</i> YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD 5-4-80 | | 7d. HOUR A.M. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>GERMANY</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>Germany</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Danham</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctors Hospital JLG Co</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BRICK LAYER</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i> | | | | | | | | | |
| 13a. STATE <i>PA.</i> | | | | 13b. COUNTY <i>CARROLL</i> | | 13c. CITY OR TOWN <i>LINEBORO</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>RD 2 Box 18</i> | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIE FEDERN</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARIE</i> | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>047-30-8916</i> | | 17. INFORMANT ADDRESS <i>MRS ERICH PROPPER Lineboro, Md 21088</i> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extend sclerotic cardiac-vascular disease</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>Deputy</i> M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>5-4-80</i> | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>May 7, 1980</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lineboro Lutheran</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lineboro Carroll Md.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>St. Charles</i> | | | | ADDRESS <i>Glenn Rock, Pa 17327</i> | | | | 25a. DATE REC'D BY REGISTRAR <i>MAY 9 1980</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. McCuskey</i> | | | | | | | | | |

MEDICAL CERTIFICATION



CHITRA



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Copy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 3 4 | |
|---|--|---|---|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Hester A. Fischer | | | 2a DATE OF DEATH 5/11/80 | | | 2b HOUR 820/P | | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH June 6 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | | 7 UNDER 1 YEAR YRS. | | 7c HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Adelphi | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a STATE Md. | | 13b COUNTY PG | | 13c CITY OR TOWN Bradbury Hg | | 13d INSIDE CITY LIMITS? NO | | 13e STREET ADDRESS 5210 Vine Street | | | |
| 14 FATHER'S NAME Unknown | | | | 15 MOTHER'S MAIDEN NAME Unknown | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO Unknown | | 17 INFORMANT Myrtle Beach, S. C. William W. Fischer, 403 40th Ave. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MYR | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 PNEUMONIA when ADMITTED 3/18/80 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from May 10 1980 to May 11 1980 , that (I) (we) lost saw the deceased alive on May 10 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE [Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 5/11/80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DR GEO DONOVAN | | | 22e ADDRESS 8218 WILSON AVE | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5-16-80 | | 23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | | 23d LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | | | |
| 24 FUNERAL DIRECTOR NAME Robt E Wilhelm | | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | | 25a DATE RECEIVED BY REGISTRAR 5/15/80 | | | 25b RECEIVED BY REGISTRAR [Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSE | | | FIRST FOLEY | | | LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 24 80 | | | 2b. HOUR 10:50P M | | | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR June 7 1892 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME, STREET AND CITY ADDRESS) Carroll Manor | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR KIND OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Prince Georges | | | 13c. CITY OR TOWN Hyattsville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 4922 La Salle Rd. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Agostino Catalano | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arminia Delia | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 088-24-2038 | | | 17. INFORMANT ADDRESS Hugh J. Foley 7 Peter Cooper Rd. N.Y., N.Y. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | | | | | | | | |
| 4049 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) HYPERTENSIVE ART. SC/CAR. REN VAS | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF DIS. | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23 1977 to 5/24 1980 , that (I) (we) lost saw the deceased alive on 5/23 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 5/24/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER | | | | | | 22e. ADDRESS 201-8 ST NE DC 20002 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 29, 1980 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Middle Village Queens N.Y. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins Funeral Home | | | | | | ADDRESS 800 Univ. Blvd. Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 29 1980 | | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | |

4900

3503-43-120

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 5 3 6
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) EDNA N. FOLKS | | | 2a. DATE OF DEATH MONTH 5 DAY 28 YEAR 1980 | | | 2b. HOUR 10:15P <small>M</small> | |
| 3 SEX Female | | 4 RACE Caucasian | | 5. DATE OF BIRTH MAY 10 19 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges <small>MD.</small> | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |

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|--|--|--|--|--|--|---|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY P.G. | | | 13c. CITY OR TOWN Ft. Washington | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 8402 Sleepy Hollow Road | | | | | |

| | | | | | |
|--|--|--|---|--|--|
| 14 FATHER'S NAME FIRST James MIDDLE G. LAST Polk | | | 15 MOTHER'S MAIDEN NAME FIRST Arnold V. MIDDLE Folks, LAST Husband, Same as Above | | |
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|--|--|--|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 579-94-9907 | | 17 INFORMANT Arnold V. Folks, Husband, Same as Above | |
|--|--|--|--|---|--|

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 5130 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) Heart Abscesses - Pneumonia | |

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|---|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes, Renal Failure, CVA, Severe Anemia | | | |
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|------------------------|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|---|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 10 19 80 , to 5/28 19 80 , that (I) (we) last saw the deceased alive on 5/26 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
|---|--|--|--|--|--|--|--|

| | | | | | | | | |
|--|--|--|--|--|--|---------------------------------|--|--|
| 22b. SIGNATURE David Lenarduzzi | | | DEGREE MD | | | 22c. DATE SIGNED 5/29/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Lenarduzzi, MD. | | | 22e. ADDRESS Hillcrest Heights, Md. | | | | | |

| | | | | | | | |
|--|--|-------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-2-80 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Natl. Cem. | | 23d. LOCATION CITY OR TOWN Suitland, P.G., Md. COUNTY P.G. STATE Md. | |
|--|--|-------------------------|--|--|--|--|--|

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|---|--|--|--|---|--|
| 24 FUNERAL DIRECTOR Robt H. Wilhelms | | 25a. DATE OF BURIAL June 3 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |
|---|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 5 3 7
CERTIFICATE OF DEATH

| | | | |
|---|-----------------|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John William France | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 - 80 | |
| 3. SEX Male | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1919 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | 7. HOUR 9:48 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hospital Center | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Supervisor of | | 12b. KIND OF BUSINESS OR INDUSTRY Dairy Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN Charles | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS P.O. BOX 252 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bertrand T. France | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Wolfe | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II 577-16-4135 | |
| 17. INFORMANT ADDRESS Ellen J. France same as 13 | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Carcinomas | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mth |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Lung | | 3 mth |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-12-80 to 5-22-80, that (I) (we) last saw the deceased alive on 5-21-80, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard Dobson M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-22-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Dobson, M.D. | | | | 22e. ADDRESS Brandywine, Maryland 20613 | | | |

| | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 27, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME HUNT FUNERAL HOME | | ADDRESS WALDORF, MD | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | 8013538 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Madeline M. Laddi</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>May 15, 1980</i> | | | 2b. HOUR <i>11:20 A</i> | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>April 23, 1894</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS. | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Pr. Geo. Co.</i> MD | | | |
| 10 CITY OR TOWN OF DEATH <i>Greenbelt</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greenbelt Conv. Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>P.G.</i> | | 13c. CITY OR TOWN <i>Greenbelt</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>7815 Mandan Rd. Apt - 104</i> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Jackson Abell</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Estelle Guy</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>217-32-9889D</i> | | 17 INFORMANT ADDRESS <i>Theresa Rankin 8204 Carrollton Pky New Carrollton, Md.</i> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> <i>0389</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110: <i>Adenocarcinoma of Breast - metastasis</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <i>4-21</i> , 19 <i>79</i> , to <i>5-15</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3-23</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>David J. Schachtel</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>5/15/80</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID Schachtel</i> | | | | 22e. ADDRESS <i>15 Graftway, Greenbelt Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5-17-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P.G. Md.</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>F. Gasch's Sons F.H. P.A. Hyatts. Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 21 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert H. Brady</i> | | | |

11:30 May 13, 1980

April 22, 1980

April 22, 1980

April 22, 1980

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 3 9 | |
|--|--|---|--|---|--------------------------|--|--|---|--|---|--|
| FOR 1 - STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| JAMES L GALLAGHER | | | | | 5 30 80 | | | | | 240 P.M. | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| M | | W | | July 31 1907 | | 72 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Wash., DC | | U.S.A. | | | | Pr. Geo. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Riverdale | | Leland Mem. Hospital | | | | Automobile Salesman | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| - | | | | - | | Wash., DC | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 144-Kentucky Ave., S.E. | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| James B. Gallagher | | | | | Sue Lowry | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | - | | 578-09-1458 Release H. Gallagher (same as above) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CARDIAC ARREST (COMPLETE HEART BLOCK) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4292 | | | | | | | | | | IMMEDIATE | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | | | | | | | | | | 10 YRS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| COPD, Fx RIPS, PNEUMONIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from May 29, 1980, to May 30, 1980, that (I) (we) last saw the deceased alive on May 30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| J. K. KELMAN | | | | | MD | | | | 5/30/80 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | | | 6/3/1980 | | Cedar Hill Cem. | | Suitland Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Nalley's F.H. Inc. | | | | | Mt. Rainier, Md. | | JUN 9 1980 | | [Signature] | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME FIRST MIDDLE LAST <i>Patricia D. GARCIA</i> | | | | | | | | | | 7a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>5-19 1980</i> | | 7b. HOUR M | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9-28-50</i> | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <i>29</i> | | IF UNDER 1 YR. MONTHS DAYS <i>5-19 1980</i> | | IF UNDER 24 HRS. HOURS MIN. <i>5-19 1980</i> | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>5-19 1980</i> | | 7d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Danham</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctors Hosp. Prince Georges City</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Virginia Arlington Arlington</i> | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>Art 105 3000 Spout Run Parkway</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank E. Prince</i> | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Shumaker</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i> | | | | 16b. SOCIAL SECURITY NO. <i>228-78-8044</i> | | | | 17. INFORMANT ADDRESS <i>Joseph E. Garcia, 3000 Spout Run Pkw Arlington, Va.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drug overdose</i> <i>9505</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>1055 P.M. 5-15-80</i> | | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Self induced</i> | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3704 Chapel Forge Rd., Prince Georges, Md.</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>Deputy</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>5-20-80</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>May 23, 1980</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bladensburg, Maryland</i> | | | |
| 24a. FUNERAL DIRECTOR <i>Robert G. Beall</i> | | | | ADDRESS <i>16000 Annapolis Rd., Bowie Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 26 1980</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Patrick McCreedy</i> | | | |

ash., D.C. U.S.A.

Housewife Home

Frank Prince Mary Elizabeth Shumaker
Arlington, Va.
228-78-8044 Joseph E. Garcia, 3000 Spout Run Pk.
no -----

Burial May 23, 1980 Ft. Lincoln Cem.
Bladensburg, Maryland
Robert C. Beall Funeral Home Bowie
16000 Annapolis Rd., Annapolis Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13541 | |
|--|----------------------|--|----------------------------------|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) John Elmer GESSNER | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5-12 1980 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 7-22-20 | 6. AGE (IN YEARS) 59 YRS. | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 7c. DATE PRONOUNCED DEAD 5-12 1980 | | 2b. HOUR 8A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | MD | | | |
| 10. CITY OR TOWN OF DEATH Suitland | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3508 Randall Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Suitland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3508 Randall Road | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Harry Charles Gessner | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Martha Skelton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 218-05-2639 | | 17. INFORMANT Dorothy C. Gessner, Wife, Same as | | | | ADDRESS Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 185- Isolated adenocarcinoma, metastatic IMMEDIATE CAUSE (a) 185- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 185- | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER | | | | DATE SIGNED 5/12-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-15-80 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1980 | | 25b. REGISTRAR'S SIGNATURE Robert E. Wilhelm | |

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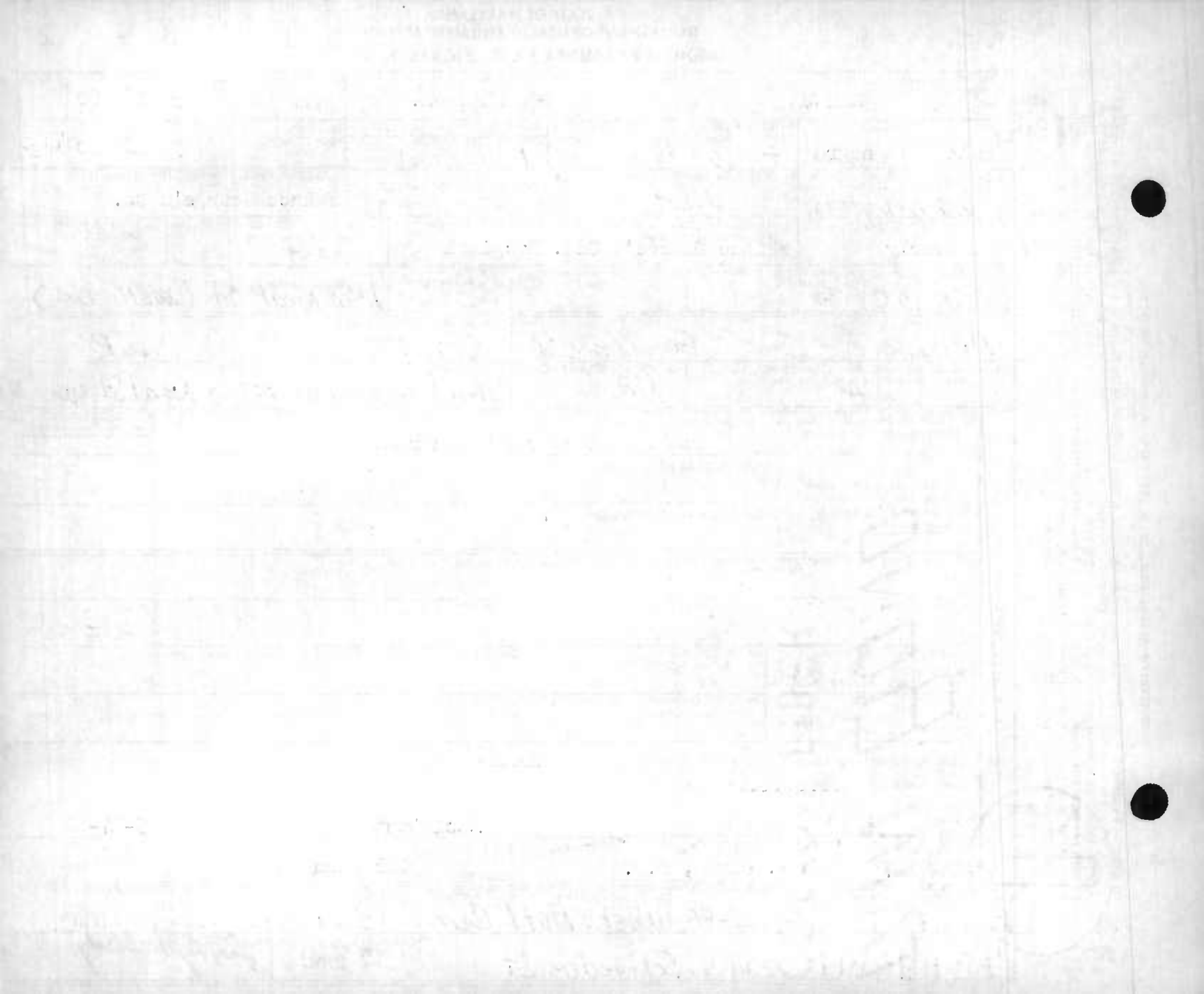
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|--|--|-------------------------------------|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 16 80 | | | | | | | | | | 2b. HOUR M 7:25 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 16 80 | | | | | | 2d. HOUR M 7:25 | |
| ARTHUR GOODMAN, JR. | | | | | | | | | | | | | | | |
| 3. SEX male | | 4. RACE negro | | 5. DATE OF BIRTH MONTH DAY YEAR 4 6 80 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 1 10 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE WASH. D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR GOODMAN, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shir/ UNK | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NA | | 16b. SOCIAL SECURITY NO. NA | | 17. INFORMANT ADDRESS Shir/ Goodman 1500 Neal St. (Wash, D.C.) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 5-17-80 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-22-80 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat'l Cern. | | 23d. LOCATION CITY OR TOWN County STATE Sudlan MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Chas H. Powell | | ADDRESS 319 N. Schroeder St. | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|-------------|--|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 0 1 3 5 4 3 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| Edith M. Griffith | | | | | MONTH DAY YEAR 5 9 80 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Female | | | | | White | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR July 31, 1915 | | | | | 64 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Wash. D.C. | | | | | U.S.A. | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | Pr. Geo. Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Riverdale | | | | | Leland Memorial Hospital | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Addressograph Oper. | | | | | N.R.I. | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | P.G. | | Cheverly | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST George Long | | | | | FIRST MIDDLE LAST Emiline Pixton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | | | 577-03-6110 | | Bette M. Dixon | | |
| | | | | | ADDRESS 10137 Prince Place Largo, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute anterior wall myocardial infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from <u>5/6</u> , 19 <u>80</u> , to <u>5/9</u> , 19 <u>80</u> , that (I) (last saw the deceased alive on <u>5/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Byrl D. Johnson</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22c. DATE SIGNED <u>5/9/80</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Byrl D. Johnson, M.D.</u> | | | | | | | | | |
| 22e. ADDRESS <u>4404 Queensbury Rd. Riverdale, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | | | | | | | | |
| 23b. DATE <u>5-10-80</u> | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u> | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood P.G. Md.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>F. Gasch's Sons F.H. P.A. Hyatts, Md.</u> ADDRESS | | | | | | | | | |
| 25. DATE REC'D BY REGISTRAR <u>MAY 15 1980</u> | | | | | | | | | |

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 4 4 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| SARAH F. GRIFFITH | | | | 5/17/80 | | | | | | 1:00A M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | WHITE | | MONTH DAY YEAR | | 65 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| North Carolina | | USA | | | | PRINCE GEORGES COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CLINTON | | SOUTHERN MD. HOSPITAL | | | | PRINTER | | Printing | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | P.G. | | TEMPLE HILLS | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5409 TEMPLE HILLS RD. | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Jno Lorenzo Lowe | | | | Mollie Wells | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | |
| No | | | | 578103555 | | Robert W. Griffith | | Same as 13e | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident, massive</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral thrombosis</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17/80 to 5/17/80, that (I) (we) lost saw the deceased alive on 5/17/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| G. H. Nachnani | | | | | | | | | | 5/17/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| G. H. NACHNANI | | | | 9015 Woodyard Road, Clinton, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| Burial | | | | 5-22-80 | | Washington Nat. Cem. | | Suitland | | P.G. Md. | |
| 24 FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| W. W. Chambers Co., Riverdale, Maryland. | | | | | | | | MAY 27 1980 | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1:00A

21/1/80

11/1/80

7

11/1/80

11/1/80

11/1/80

11/1/80

11/1/80

PRINCE GEORGE COUNTY

11/1/80

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11/1/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 3 5 4 5 | |
|---|--|--|--|--|--|---|--|--|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST Edith | | MIDDLE C. | | LAST Haliburton | | 2a. DATE OF DEATH MONTH DAY YEAR 5 11 80 | | 2b. HOUR 8:40 a.m. | |
| 3 SEX Female | | 4 RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 5 19 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7a. UNDER 1 YEAR MONTHS DAYS | | 7b. UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Oxon Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 40 Alexandria Dr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Clerical | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 40 Alexandria Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Haliburton | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Kirby | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO none | | 17 INFORMANT Norma Carrington | | ADDRESS same as item 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death 1 hr. 5 years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 22 1974 to May 11 1980, that (I) (we) last saw the deceased alive on April 19 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. Sanford Young | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/12/80 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sanford Young | | 22e. ADDRESS 9401 Indian Head Highway Oxon Hill, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/14/80 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Jamaica Plains Mass. | | | | | |
| 24 FUNERAL DIRECTOR NAME G.P. Kalas | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

Medical Examiner Notified and Approved

MEDICAL CERTIFICATION

never again has petition returned 1 01501

... 6100 Oxon Hill 6. Oxon Hill, Md.

Forest Hills Cemetery, Jamaica Plain, Mass.

2601 Indian Head Highway Oxon Hill, Md.

April 19

60

May 11

30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 3 5 4 6 | | |
|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | |
| BEULAH S HALL | | | | | 05 11 80 | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | |
| Female | | White | | 3- 4 -1912 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | |
| Virginia | | USA | | 68 | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| CHEVERLY | | PRINCE GEORGES GENERAL HOSP. | | PRINCE GEORGES MD. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | |
| 13a. STATE | | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. 3341 Buchanan St. | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Jim Crigger | | Julia Calahan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | |
| no | | 231-32-7655 | | Mrs. Cecil Hall, Mt. Ranier, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | |
| 5335 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Perforated Peptic Ulcer.</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 5/8/80 | | Perforated Ulcer and Pneumonia | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/7/80</u> to <u>5/11/80</u> , that (I) (we) last saw the deceased alive on <u>5/11/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| V. P. Chandan | | | | MD | | 5/11/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Venkateswaram Prem Chandan | | | | 6001, Landover Rd, Chevy Chase, Md 20785 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/14/80 | | Crigger Cemetery | | Wythe Va. | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Barnett Funeral Home, Wytheville, Va. | | | | MAY 15 1980 | | Lillian K. Keady | |

Burial 2/1/80 Griggs Cemetery Wythe Va.

no 251-32-7622 Mrs. Cecil Hall, Mt. Vernon, Mo.

Jim Griggs Julia Calahan

Mr. Prince George Mt. Vernon x 3341 Buchanan St.

OVERSEAS PRINCE GEORGE GENERAL CO. P. O. BOX 10000
USA x 10100

Female White 3-4-1912 60

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR THE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jesse V. HALL | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED 5-6-80 | | | | | | | | | | 2b. HOUR 8 | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 5-6-80 | | | | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 3 DAY 24 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | 7c. DATE PRONOUNCED DEAD 5-6-80 | | | | | | | | | | 2d. HOUR 8 | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI | | | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prima George | | | | | | | | | | MD | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Chesley (POA) | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prima Georges General Hosp | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATCHMAN | | | | 12b. KIND OF BUSINESS OR INDUSTRY PRIVATE | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | | | | | | | | | 13b. CITY OR TOWN PRINCE GEORGES | | | | 13c. CITY OR TOWN LANHAM | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 8918 FAIRVIEW AVENUE. | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST GEORGE MIDDLE HALL LAST HALL | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST ADELINE MIDDLE UNKNOWN LAST UNKNOWN | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. 180-24-2698-A | | | | 17. INFORMANT ADDRESS Lanham, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | | | | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 5-6-80 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | | | | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | | 23b. DATE May 9, 1980 | | | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Maryland | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ROLLINS FUNERAL HOME, INC. 4339 Hunt Pl. N. E. | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR MAY 12 1980 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | |



11-88

UNITED STATES

DEPARTMENT

RECEIVED

PRIVATE

RECEIVED BY THE DIRECTOR

XX

8018 BAYVIEW AVENUE

GEORGE

HAIR

AUSLIER

UNION

San Francisco, California

180-24-998-A Mrs. Joe L. Hall - 8018 Bayview Avenue

11-88

11-88

11-88

San Francisco, California

Nov 9, 1980

11-88

RECEIVED BY THE DIRECTOR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (S))
15M/7/77

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13548 | |
|---|-----------------------------|--|--|---|---|--|-------------------------|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Philip G. HANNUM Sr. | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-3 1980 | | | 2b. HOUR 3:15 PM | | | | | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 7-5-24 53 YRS. | 6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS. | IF UNDER 1 YR. MONTHS DAYS MIN. | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-3 1980 | 7d. HOUR 3:15 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Sanham | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital & P.G. Co | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookbinder | | 12b. KIND OF BUSINESS OR INDUSTRY GPO | | | |
| 13a. STATE Virginia | | | 13b. CITY OR TOWN Falls Church | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 303 Randolph Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edmond Burkhley Hannum | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tingersol | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 1943-1946 151-16-5925 | | 17. INFORMANT G. Jr. ADDRESS Philip Hannum Same as 13c | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Vasculodisease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez M.D. | | | TITLE (SPECIFY) Deputy | | | MEDICAL EXAMINER | | | DATE SIGNED 5-7-80 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 7 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pleasantville, NJ. | | | |
| 24. FUNERAL DIRECTOR Beall Funeral Home | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1980 | | | 25b. REGISTRAR'S SIGNATURE John H. H. H. | | | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows in several paragraphs]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

208-10101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 180 G544 6/24/80 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---------------------|--|---------------------|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2. DATE OF DEATH | | | 3. HOUR | | | |
| ANGELA GRACIA HARDEE | | | MAY 24 1980 | | | 2:00P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | JANUARY 23, 1933 | | 47 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| SPAIN | | SPAIN | | | | PRINCE GEORGES COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANDREWS AFB | | MALCOLM GROW USAF MEDCEN | | | | HOUSEWIFE | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | |
| N. CAROLINA | | | JOHNSTON | | SMITHFIELD | | 206 SOUTH ROGERS DR | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| ANGEL GRACIA RUIZ | | | PALMIRA GRACIA MALERO | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| NO | | | 251-94-8056 | | RONALD ALLEN HARDEE | | N.C. 27577 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | IMMEDIATE CAUSE (a) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1229 | | | cardiac arrest | | | 2 m | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | (b) | | | 3 weeks | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | (c) | | | 4 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | neurological death | | | Pending path | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1980, to May 24, 1980, that (I) (we) lost saw the deceased alive on May 24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | |
| Gail M. Vivian MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 24 MAY 1980 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| GAIL M. VIVIAN | | | MG USAF MC, ANDREWS AFB MD 20331 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| burial | | 5-28-80 | | Selma Memorial Gardens Selma, N. C. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Evenly-Wheatley | | | Alexandria, VA. | | | JUN 2 1980 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | | |

Every-Wheatley Alexander, Jr.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

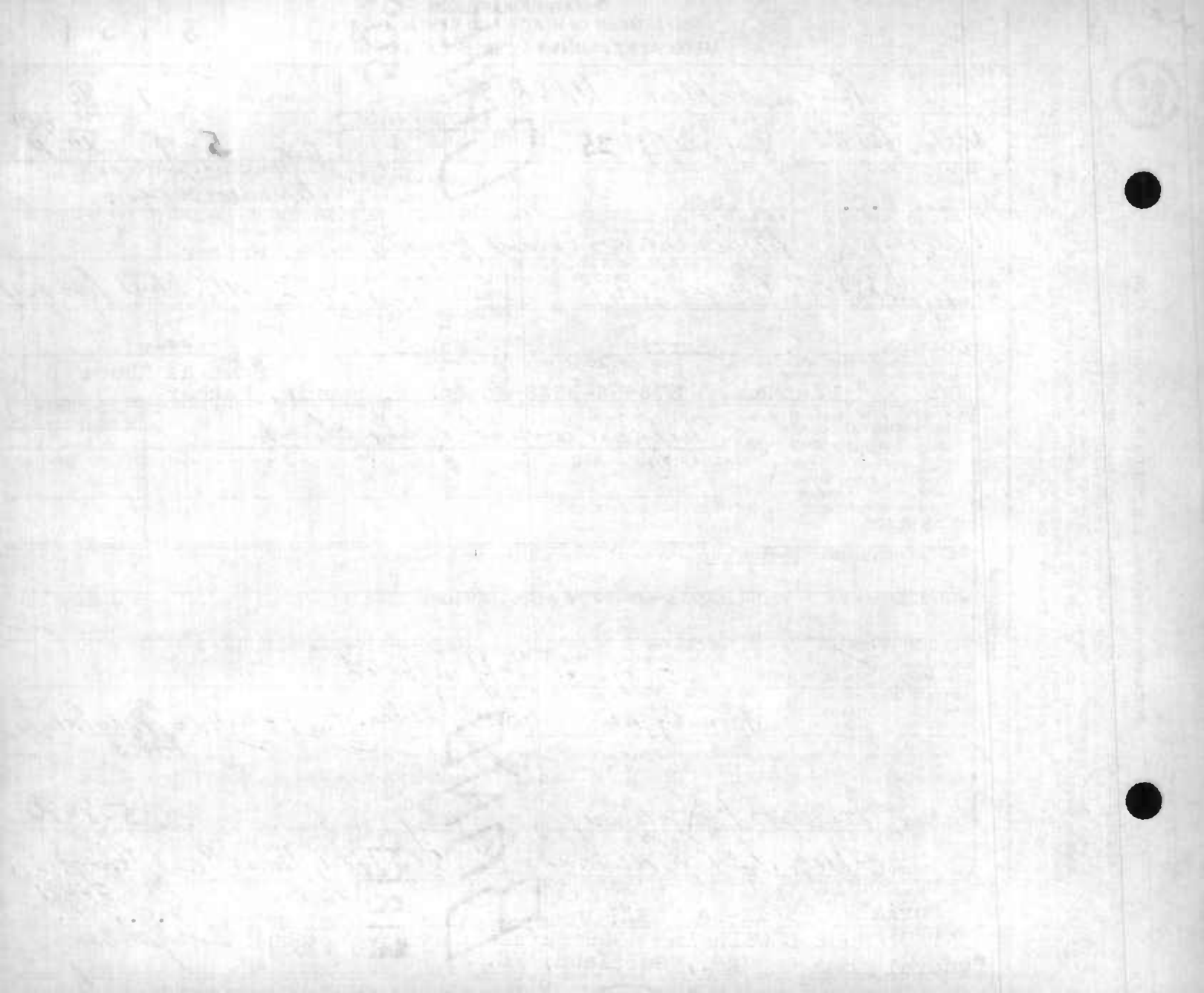
| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13550 | | | | | | | | | | | | | |
|---|--|------------------|--|-----------------------------|--|------------------------------|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|---|--|-----------------------|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE F. HARMAN, JR. | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED 5-3 1980 | | | | | | | | | | 2b. HOUR 4:30 PM | | | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 7-16-23 | | 6. AGE (IN YEARS) 56 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED 5-3 1980 | | | | | | | | | | 2d. HOUR 4:30 PM | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | MD. | |
| 10. CITY OR TOWN OF DEATH Chesley | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Military | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Pr George | | | | | | | | | | 13c. CITY OR TOWN Hillcrest Ht | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4003 Norcross Street | |
| 14. FATHER'S NAME George F. Harman, Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME Sylvia Evlyn Cryder | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. 1941-1961 | | | | | | | | | | 17. INFORMANT Yolanda Harman | | | | | | | | | | ADDRESS Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Ethanol abuse.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | | | | | | | TITLE (SPECIFY) Deputy | | | | | | | | | | MEDICAL EXAMINER | | DATE SIGNED 5-4-80 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | | | | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 7 May 1980 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG County Md | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | | | | | | | ADDRESS Funeral Home Inc | | | | | | | | | | SUITLAND, MD. | | | | | | | | | | | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE





| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13551 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Raymond Alan HARRIS</i> | | | | | | | | | | 20. DATE KNOWN OF DEATH <i>5-7 1980</i> | |
| 3. SEX <i>Male</i> 4. RACE <i>White</i> 5. DATE OF BIRTH <i>8-10-44</i> 6. AGE (IN YEARS) <i>35</i> YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i> 8. CITIZEN OF WHAT COUNTRY? <i>USA</i> 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 10. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> | | | | | | | | | | 21. DATE PRONOUNCED <i>5-7 1980</i> | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Prince Georges Naval Hospital</i> 12. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Tech. Writer</i> 13. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | 14. CITY OR TOWN OF DEATH <i>Chesley</i> | |
| 15. USUAL RESIDENCE (TYPE OF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Prince Georges Naval Hospital</i> 16. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 17. STREET ADDRESS <i>14982 4th Street Apt 204</i> | | | | | | | | | | 18. CITY OR TOWN OF DEATH <i>Chesley</i> | |
| 19. FATHER'S NAME <i>Joseph M. Harris</i> 20. MOTHER'S MAIDEN NAME <i>Mabel Sheffer</i> 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> 22. SOCIAL SECURITY NO. <i>578-56-3548</i> 23. INFORMANT <i>Same as Above</i> | | | | | | | | | | 24. CITY OR TOWN OF DEATH <i>Chesley</i> | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shotgun wound of the chest</i> 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <i>9551</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>9551</i> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>5-7 1980</i> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Self inflicted</i> | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home Office</i> 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) <i>7514 Matha St. Forestville Prince Georges</i> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusta P. Pringle</i> MEDICAL EXAMINER DATE SIGNED <i>5-8-80</i> | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusta P. Pringle</i> ADDRESS <i>5009 Payson Court, Camp Springs, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> 23b. DATE <i>5-12-80</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Md. Veterans Cem.</i> 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <i>Cheltenham, P.G., Md.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i> 4308 Suitland Rd., Suitland, Md. 25. DATE REGD. BY REGISTRAR <i>MAY 14 1980</i> 26. REGISTERED ADDRESS <i>Pringle, M. Pringle</i> | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

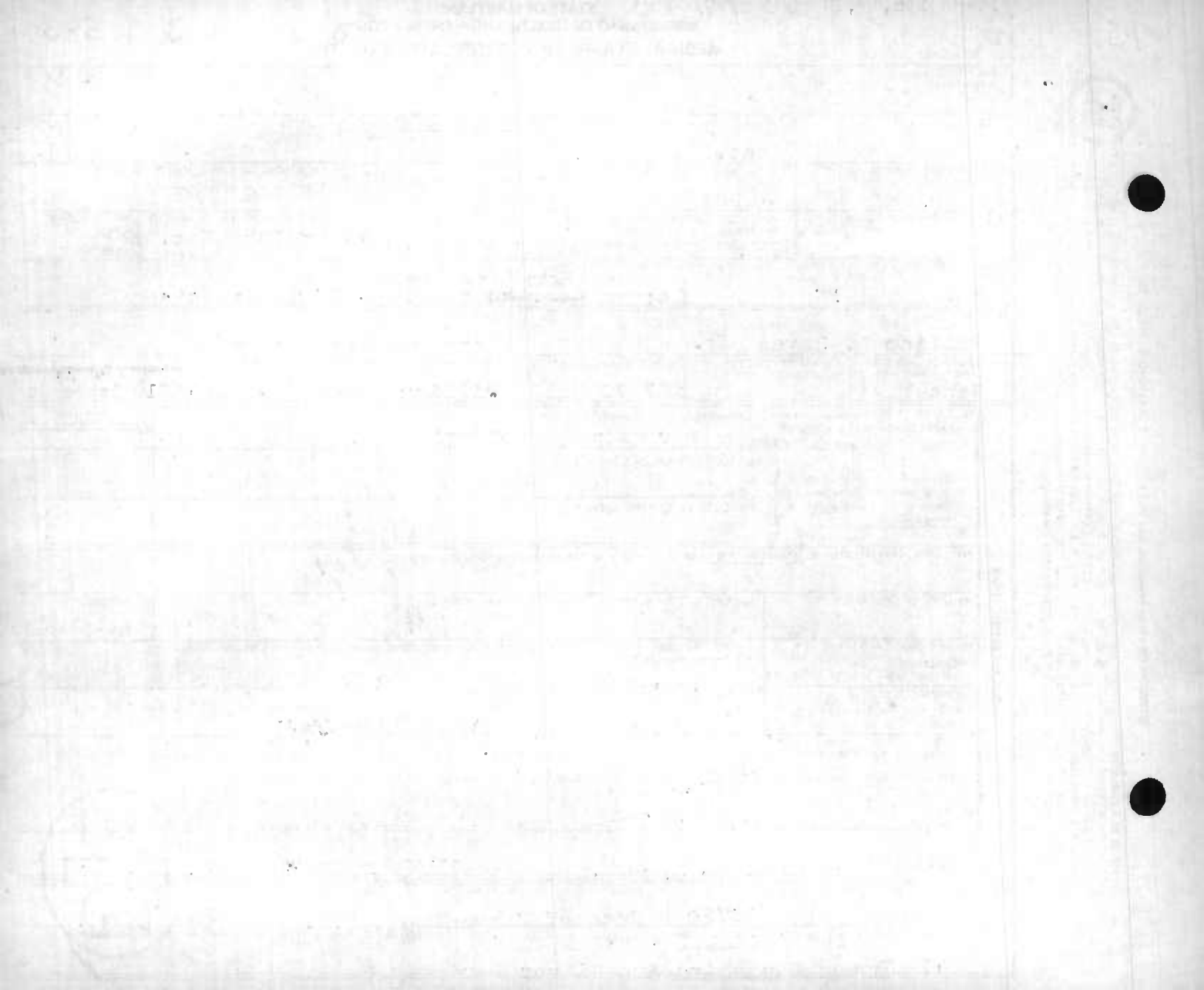
| | | | | | | | | |
|---|-------------------------|---|---|---|--|--|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Mary HAWKINS | | | 2a. DATE OF DEATH KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 5-7 1980 | | | 2b. HOUR M 3:30 | | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7-7-98 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 81 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 5-7 1980 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | |
| 10. CITY OR TOWN OF DEATH Chesley, Md | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Washington, D.C. | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 5409 4th Street, N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Savoy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Curtis | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | |
| 16b. SOCIAL SECURITY NO. 579 12 2959A | | | 17. INFORMANT Mrs. Esther Persons-Daughter | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez M.D. | | | TITLE (SPECIFY) Deputy | | | DATE SIGNED 5-7-80 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 10, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, | |
| 24. FUNERAL DIRECTOR NAME Stewart | | | 24b. ADDRESS Funeral Home-4001 Benning Road, NE. | | | 25a. DATE 1 3 1980 | | |
| 25b. REGISTRAR'S SIGNATURE Shirley M. Cready | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

| 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13553 | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|--|--|--|----------------------------|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JUDITH L. HAYES | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 5-9-80 | | | | | | | | | | 2b. HOUR 10:10 A.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 57 | | 6. AGE (IN YEARS LAST BIRTHDAY) 22 RS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 5-9-80 | | | | | | | | | | 2d. HOUR 10:10 A.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING CIRCLES) Manor Care, Inc. Book Keeper | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY PG | | | | | | | | | | 13c. CITY OR TOWN Hgts Berwyn Heights | | | | | | | | | | 13d. INSIDE CITY LIMITS? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 6010 Osage Street | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. Hayes Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Dixon | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None | | | | | | | | | | 16b. SOCIAL SECURITY NO. 217 72 3235 | | | | | | | | | | 17. INFORMANT ADDRESS William Hayes (Father) 6010 Osage St | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CRANIO-CEREBRAL INJURY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8150 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 1:30 a.m. 5-9-80 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto that hit pole. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Beltway 495 | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Ramp to Rt. 1 Northbound | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | | | | | | | TITLE (SPECIFY) Deputy Chief | | | | | | | | | | DATE SIGNED 5-10-80 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | | | | | | | ADDRESS 111 Penn Street, Balto., MD. 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 5/13/80 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE May S. Sggs Mont Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HINES/RINALDI FUNERAL HOME | | | | | | | | | | 25a. DATE OF BURIAL 5/11/80 | | | | | | | | | | 25b. SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11800 New Hampshire Ave Silver Spring, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|-------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8013554 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| BLANCHE HEIM | | | | | 05 14 80 12:21PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. HOUR | |
| Female | | White | | January 5, 1893 | | 87 YRS. | | 12:21PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MD. | |
| Washington DC | | U.S.A. | | | | PRINCE GEORGES | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CHEVERLY | | PRINCE GEORGES GENERAL HOSPITAL | | Housewife | | n / a | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Pr Geo | | Dist. Hts. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6032 Parkland Court #101 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| Jesse | | Kate | | No | | 214 03 8038 | | Erma F. Fulton Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Ag. M.I. (Myocardial Infarction)</u> | | | | | | | | | |
| (c) <u>Chronic obstructive lung disease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. PLACE OF INJURY | | 21e. LOCATION | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | P.M. 19 | | CITY OR TOWN COUNTY STATE | |
| 21a. INJURY OCCURRED | | 21b. PLACE OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. PLACE OF INJURY | | 21e. LOCATION | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> 19 <u>80</u> , to <u>5-14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>Rustagi</u> | | M.D. | | | | <u>Resident</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | |
| RAVINDER K. RUSTAGI, M.D. | | P.G. GENERAL HOSPITAL, CHEVERLY, MD | | MAY 19 1980 | | <u>Histroy McCreedy</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| Burial | | 16 May 1980 | | Epiphany Ch. Cem | | Forestville PG | | Md | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm | | Funeral Home Inc | | Suitland, Md. | | | | | |

02 14 00 13:214

PRINCE GEORGES

CHEVERLY PRINCE GEORGES GENERAL HOSPITAL

PRINCE GEORGES GENERAL HOSPITAL

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PRINCE GEORGES GENERAL HOSPITAL

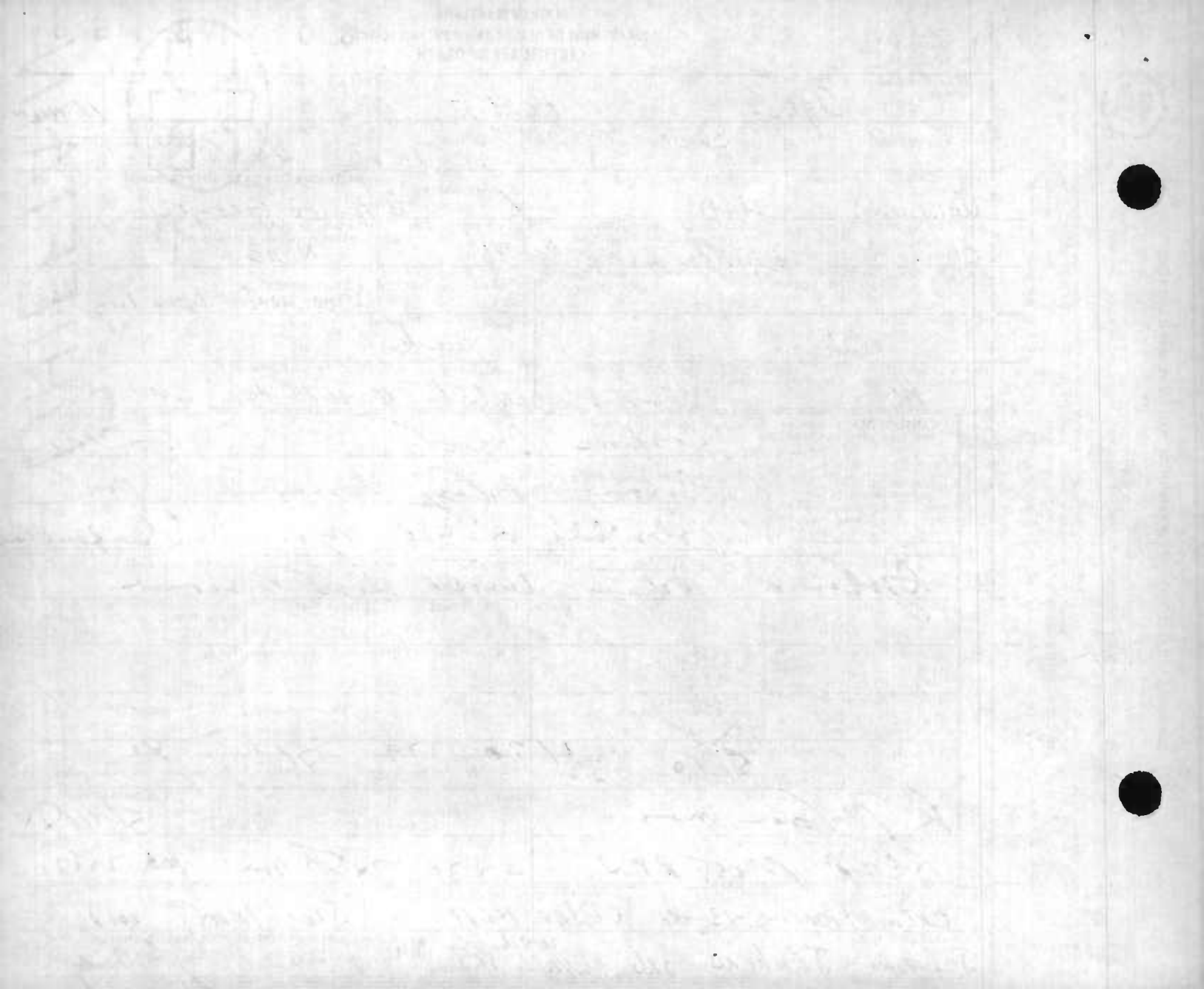
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 5 5 | |
|---|--|--|--|---|---|---|---|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Agnes Herbert</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5 11 1980</i> | | 2b. HOUR <i>12 noon</i> | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 29 1896</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. | | # UNDER 1 YEAR MONTHS DAYS | | # UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Unknown</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Clinton</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Clinton Conv. Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NONE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>✓</i> | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS <i>2700 Martin Luther King Ave. St.</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>unk</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unk</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | | | 16b. SOCIAL SECURITY NO. <i>518-68-0368</i> | | 17. INFORMANT ADDRESS <i>Ry. St. Elizabeth Hosp WASH DC</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yes</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Bohemian - Open Stenotic Heart Disease</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>5/10</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/30</i> 19 <i>79</i> , to <i>5/11</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>5/10</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>R. Morgan, MD</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>5/11/80</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>REZA MOSTAFAN</i> | | | | | | 22e. ADDRESS <i>4235 25th Ave MD 20431</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i> | | 23b. DATE <i>5-13-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>CEAR Hill</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>SCATLAND MD</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>JOHNSON & JENKINS</i> | | ADDRESS <i>716 KENNEDY ST NW WASH DC</i> | | 25. DATE REC'D. BY REGISTRAR <i>MAY 22 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert</i> | | | | | |

BP



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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8013556 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE M. HERBERT | | | | 2b. HOUR 10 ²⁰ A.M. | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 17, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. Co. | | 13c. CITY OR TOWN Crofton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles - Gray | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - (Unknown) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO 577-34-4317 | | 17. INFORMANT ADDRESS John E. Hardy (Son) Same as # 13. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe congestive heart failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardiovascular insufficiency</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/6/80</u> to <u>5/23/80</u> , that (I) <u>yes</u> lost saw the deceased alive on <u>5/23/80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>E. Nemat, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED May 23, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. NEMAT, M.D. | | | | 22e. ADDRESS 4235-28th Ave. Marlow Heights, Md 20031 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May/27/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO. | | | | 24b. ADDRESS RIVERDALE - MD | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

January 17, 1931

My dear Sir:

x

Very truly yours,

W. W. C. C.

Very truly yours,

W. W. C. C.

Very truly yours,

W. W. C. C.

Very truly yours,

W. W. C. C.

Very truly yours,
(Signature)

(Signature)

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 5 7 | |
|---|--|--|--|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) LAUGHAN I. HOCKMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 05-20-80 | | | 2b. HOUR. 4.05P.M. | | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 18 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 0 0 | | 7. UNDER 24 HRS HOURS MIN. 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Cap. Hgts. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 608 Opus Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Nairn | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rena Staub | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 578-46-7668A | | 17. INFORMANT ADDRESS Elmer L. Hockman, Same as Above, Wife, | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 496- DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5-8 19 80 , to 5-20 19 80 , that (1) <input checked="" type="checkbox"/> lost saw the deceased alive on 5-20 19 80 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Louis Steinberg | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Steinberg | | | 22e. ADDRESS 6492 Landover Rd Landover Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-23-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b. REGISTRAR'S SIGNATURE Henry M. Brady | | | |

LAVERGNE 1. HODGINS 2-20-80 4:15P.M.

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

STANDARD-VEHICLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY ISADORE HOFFMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 14 80 | | 2b. HOUR P M 11:10 AM | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR SEPT 25, 1923 | | 6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY D.C. WATER DEPT | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | | | 13b COUNTY PRINCE GEO | | 13c. CITY OR TOWN W. HYATTSVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST EMANUEL HOFFMAN | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN STEWART | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17 INFORMANT IDA F. HOFFMAN | | ADDRESS SAME AS 13 | | WIFE | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/11/80</u> , 19 <u>80</u> , to <u>5/14/80</u> , that (I) (we) lost saw the deceased alive on <u>5/14/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE <u>Thomas J. Hernandez</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 5/15/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS J. HERNANDEZ MD. | | | | | 22e ADDRESS P.G.G.H. & M.C. CHEVERLY, MARYLAND 20785 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 5/19/80 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD. | | | | |
| 24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Robert M. Cuddy</u> | | | |

500 UNIT BLVD. N. SILVER SPRING, MD. 20901
FRANCIS J. COLLINS

BURIAL 2/19/80 FT. LINCOLN CEMETERY BRETHWOOD PRG GEO. MD.

THOMAS J. WERHANNEDT MD. P.O. BOX 100, CHEVERLY, MARYLAND

Colonel James Stewart
Post Office Box 100
Cheverly, Maryland

WIFE WM 11 579-14-0104 104 F. HOFFMAN SA 12 12 WIFE

ELWELL HOFFMAN HOFFMAN STEWART

HARVARD PRINCE GEO. H. HAVATTSVILLE X 2812 25TH PLACE

CHEVERLY PRINCE GEORGE'S GENERAL HOSPITAL SUPERVISOR T.C. WATER BETT

WASHINGTON, D.C. U.S.A. PRINCE GEORGE'S COUNTY

MALE WHITE SEPT 23, 1923 28

HENRY ISADORE HOFFMAN 11.10

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13559

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>James</i> | | FIRST <i>E</i> | | MIDDLE <i>HOLMAN</i> | | LAST | | 2b. DATE OF DEATH KNOWN OF ESTI- MATED <i>5-12</i> 19 <i>80</i> | | 2c. DATE OF DEATH PRONOUNCED DEAD <i>5-12</i> 19 <i>80</i> | | 2d. HOUR <i>3:25</i> P M | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH <i>10</i> DAY <i>10</i> YEAR <i>1944</i> | | 6. AGE (IN YEARS) LAST BIRTHDAY <i>35</i> YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> | | 10. CITY OR TOWN OF DEATH <i>Cheserly</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS <i>Prince Georges General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE <i>MD.</i> | | 13b. CITY OR TOWN <i>P.G.</i> | | 13c. CITY OR TOWN <i>SEAT PL.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>917 Minna Ave.</i> | | | |
| 14. FATHER'S NAME FIRST <i>(Unknown)</i> MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i> MIDDLE <i>(Unknown)</i> LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>579-54-7599</i> | | 17. INFORMANT <i>Otis E. Molman</i> | | ADDRESS <i>1415 Farmingdale Chapel Oaks, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Myocardial infarction with atherosclerotic coronary disease</i> <i>4029</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Chronic obstructive pulmonary disease</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | TITLE (SPECIFY) <i>Deputy</i> | | MEDICAL EXAMINER | | DATE SIGNED <i>5-13-80</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>5/15/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>FOREST HILLS</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>CLINTON, MD.</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>MORROW & WOODFORD, INC.</i> ADDRESS <i>1622 11th. St. N.W. Wash., D. C. 20001</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 15 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 70 | | 13560 | |
|--|--|---|--|--|--|--|--|---|--|-------------------|--|-------|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2. DATE OF DEATH | | | | 3. HOUR | | | | | |
| BENJAMIN H. HOLSINGER | | | | 05-03-80 | | | | 5:00AM | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | | | |
| MALE | | WHITE | | JAN. 23, 1889 | | 91 | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Pennsylvania | | U.S.A. | | | | PRINCE GEORGES | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| CHEVERLY | | PRINCE GEORGES GENERAL HOSPITAL | | Accountant | | Self Employed | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | | |
| Maryland | | | | Prince Geo. | | | | University Pk. | | | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | |
| Paul | | | | Unknown | | | | No | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, SEVERE BOTH LUNGS 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| 537 16 4474 | | | | M. Paul Holsinger | | | | 22 Lateer Drive Normal, Ill. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 67 to July 3, 19 80, that (I) (we) lost saw the deceased alive on July 2, 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| ROBERT DEITZ | | 6525 BELCREST RD HYATTSVILLE MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 5/7/80 | | Ft. Lincoln Cem. | | Brentwood P.G. County Md. | | | | | | | |
| 24. FUNERAL DIRECTOR Francis Gansch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |



DATE: 11/17/1940

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

FROM: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11/17/1940

URGENT

URGENT

X

Very truly yours,

J. Edgar Hoover, Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

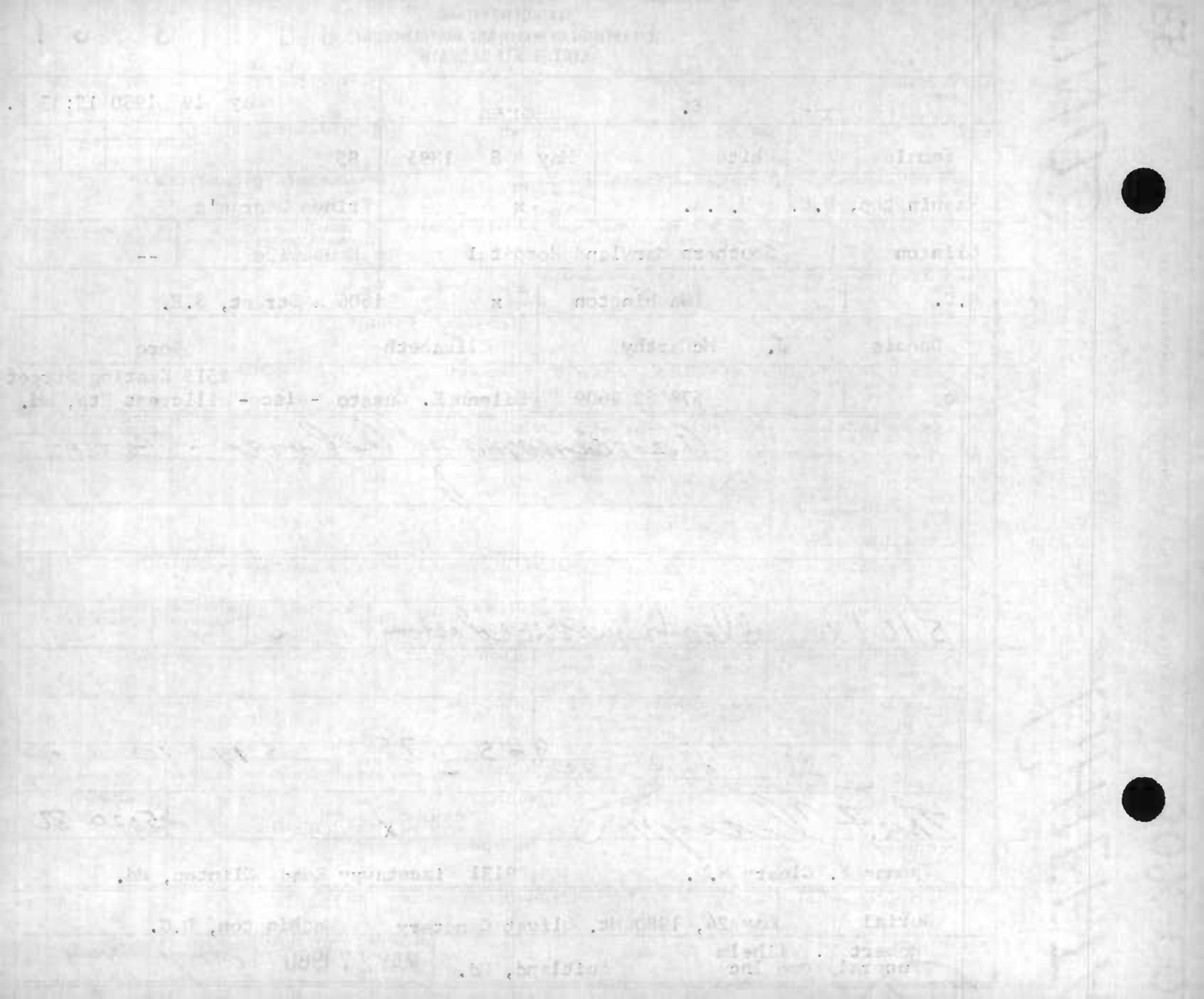
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 417-7500.

BP

DHMH-16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|---|----------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| FOR 1. STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E. Horan | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 19 1980 | | | | | 2b. HOUR 12:33 P. M. |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR May 8 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1606 A Street, S.E. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dennis J. McCarthy | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Dore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 62 9609 | | 17. INFORMANT ADDRESS 2515 Keating Street Eileen E. Cusato -Niece- Hillcrest Hts, Md. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/6/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ileo transverse colectomy | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-5, 1975, to 5-19, 1980, that (I) (we) last saw the deceased alive on 5-19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.) | | | | | | | | | | |
| 22b. SIGNATURE Thomas F. Cleary M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-20-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Cleary M.D. | | | | | 22e. ADDRESS 9131 Piscataway Road Clinton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 24, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home Inc | | | | | ADDRESS Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 0 1 3 5 6 2 | | | | |
|---|--|--|--|--|--|---|--|--|----------------------------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD G. HORSTKAMP SR. | | | | | 2a. DATE OF DEATH MONTH 05 DAY 18 YEAR 80 | | | | 2b. HOUR 11:10PM |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH July DAY 6 YEAR 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. HOSP & MED CTR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Express Clerk- RR Exp. Agency | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN W. Hyattsville | | | | | 14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13d. STREET ADDRESS 2725- Nicholson St. | | |
| 14. FATHER'S NAME FIRST William MIDDLE F. LAST Horstkamp | | | | | 15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE M. LAST Corbin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT Angela G. Horstkamp (above address) | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular asystole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11:0 P.M. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) Cerebrovascular accident. Hypertension & H.C.V.D. Diabetes - diet controlled | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 P.M. MAY 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 13th May 1980 to 18th May 1980 , that (I) (we) last saw the deceased alive on 12th May 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 19th May 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PADMAJA UDARI. | | | | 22e. ADDRESS Prince Georges General Hospital Cheverly MD 20725 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/21/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN Brentwood COUNTY Pr. Geo. STATE Md. | | | |
| 24. FUNERAL DIRECTOR'S NAME Valley's F.H. Inc. Mt. Rainier, Md. | | | | | | | | | |
| DATE REC'D BY REGISTRAR MAY 26 1980 | | | | | | | | | |

10

UNITED STATES
DEPARTMENT OF JUSTICE

RECEIVED
JAN 10 1964

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK

RE: PRINCE GEORGE COUNTY

RE: PRINCE GEORGE COUNTY, MARYLAND, JANUARY 10, 1964

RE: PRINCE GEORGE COUNTY, MARYLAND, JANUARY 10, 1964

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RE: PRINCE GEORGE COUNTY, MARYLAND, JANUARY 10, 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| FOR 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALThea V Howard | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 12 80 | | | | 2b. HOUR 3:20 A.M. | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 28 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH P.G. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian | | 12b. KIND OF BUSINESS OR INDUSTRY District | | | |
| 13a. STATE Wash. D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9211 Stuart Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles E Howard | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Barks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 317-208579 | | 17. INFORMANT ADDRESS John T. Martin 5026 10th St. N.E. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENDOMETRIAL CARCINOMA 1820 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11 , 19 80 , to 5/12 , 19 80 , that (I) (we) lost saw the deceased alive on 4/15 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Raymond W Turner | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/12/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND W TURNER | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial | | 23b. DATE 5/1 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Robert G. Mason, Inc. | | | | ADDRESS 1661 Gooch Rd. S.E. D.C. | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1980 | | 25b. REGISTRAR'S SIGNATURE Barbara McHenry | | | |

BP

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--------------------------------------|---|------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| FIRST MARY | | MONTH DAY YEAR 5-10 1980 | | M | |
| MIDDLE V. | | LAST HOWARD | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Female | White | MONTH DAY YEAR 8-03-06 | 73 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR DISTRICT OR TERRITORY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington DC | USA | NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Prince George's | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Chesley | Prince Georges General Hospital | Retired-Printing | US Gov't | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | 13c. STREET ADDRESS | | |
| 13a. STATE D. C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2806 Erie Street, S.E. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST Thomas Pace | | FIRST MIDDLE LAST Mary Mann | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 578 54 1230A | | R Daniel Howard 12205 Maycheck Lane Bowie, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Submucous thrombosis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerosis, Right hip fracture, chronic obstructive pulmonary disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| 4-28-80 | | Intertrochanteric fracture | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 7 P.M. 4-27 1980 | | Fell at home | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Home | | 403 Kettering Ct., Upper Marlboro Prince Georges Md. 20870 | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Augusto P. Rodriguez | | Deputy | | 5-11-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Augusto P. Rodriguez M.D. | | 5009 Rayburn Ct., Camp Springs Md. 20031 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 13 May 80 | | Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR'S NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E Wilhelm Funeral Home | | MAY 1 1980 | | P. J. McCready | |
| Suitland Maryland | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------|--|---|--|--|--|---|--|-------------------------------|--|--|--|-----------------------------------|--|---|--|---|--|----------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Hillis Monroe | | MIDDLE HOWELL | | LAST HOWELL | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH 5-13 | | DAY 19 | | YEAR 80 | | 2b. HOUR M | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3-9-31 | | 6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | MONTH 5-14 | | DAY 19 | | YEAR 80 | | 2d. HOUR 3P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | | | | 12b. KIND OF BUSINESS OR INDUSTRY Post Office | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | | | | | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5001 Lackawanna Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fred Howell | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel I. Mc Cormick | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korea | | | | 16b. SOCIAL SECURITY NO. 232-48-1223 | | | | 17. INFORMANT Josephine M. Howell | | | | ADDRESS 8801 60th. Ave. Berwyn Heights, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-14-80 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez | | | | ADDRESS 5009 Rayburn Court, Camp Springs, Md. 20746 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-19-80 | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR MAY 20 1980 | | | | 26. REGISTRAR'S SIGNATURE Rising | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 5 6 6 | | | |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) JOHN HUPP | | | | 2a DATE OF DEATH MAY 5 1980 | | 2b HOUR 12:20PM | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH SEP 5 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATCHMEN | | 12b. KIND OF BUSINESS OR INDUSTRY Security | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Camp Springs | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME Joseph Hupp | | | | 15 MOTHER'S MAIDEN NAME Anna Fleasch | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO 577-18-2677 | | 17 INFORMANT ADDRESS Louise Sylvester same as item 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY 5 MAY 19 80 HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 MAY 19 80 to 5 MAY 19 80 , that (I) (we) last saw the deceased alive on 5 MAY 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edward G. Rupert DEGREE | | | | | | 22c. DATE SIGNED 5 MAY 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD G. RUPERT, MAJ, USAF, MC | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/9/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | |
| 24 FUNERAL DIRECTOR NAME G.P. Kalas | | | | 24b. ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | |
| 24c. DATE REC'D. BY REGISTRAR MAY 8 1980 | | | | 24d. REGISTRAR'S SIGNATURE [Signature] | | | |



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CERTIFICATE OF DEATH

REG NO

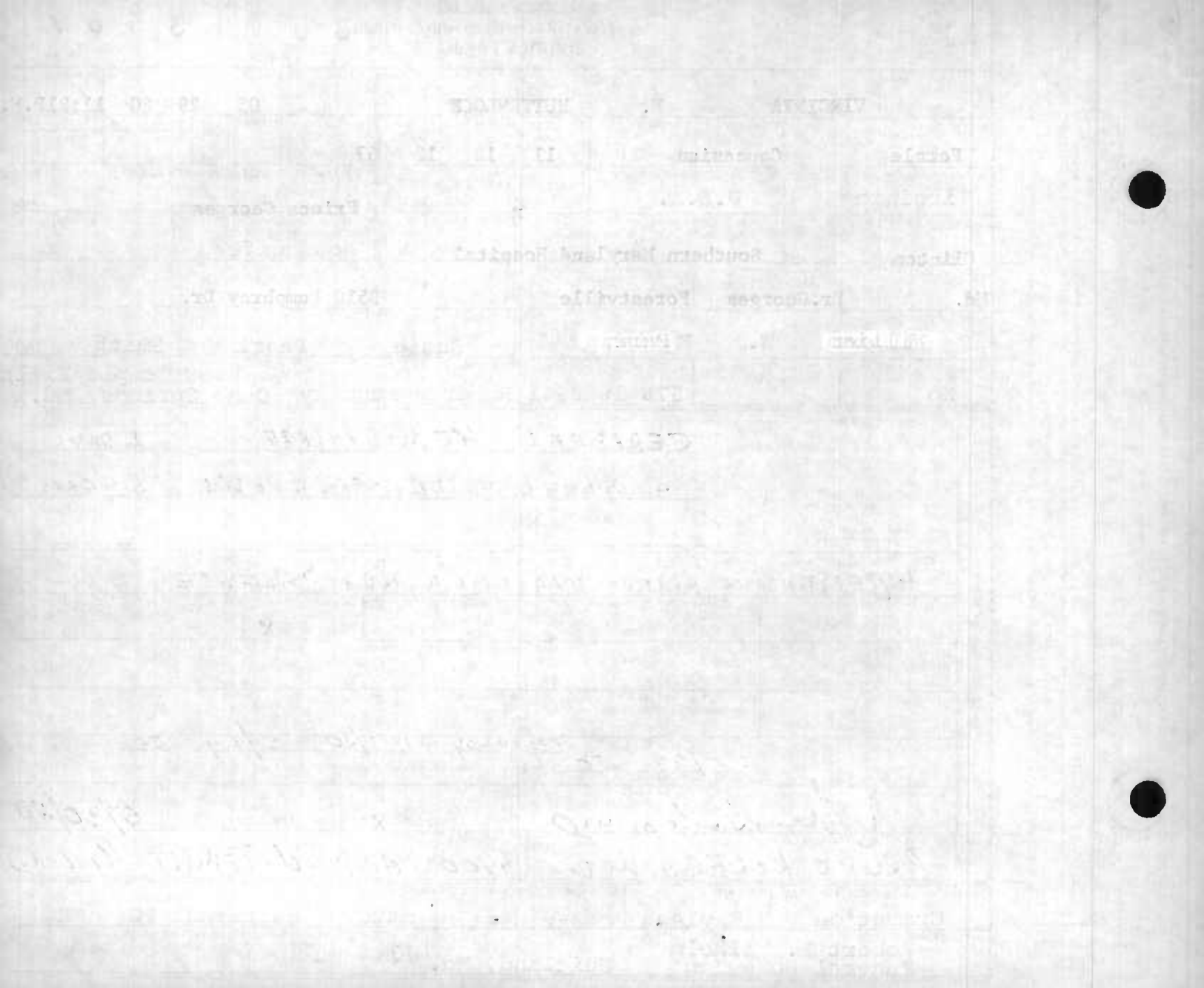
1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA F. HUTTENLOCH | | | 2a. DATE OF DEATH MONTH 05 DAY 29 YEAR 80 | | | 2b. HOUR 11:21 P.M. | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 11 DAY 12 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY Pr. Georges | | 13c. CITY OR TOWN Forestville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST Gilbert MIDDLE W. LAST Farrish | | | 15. MOTHER'S MAIDEN NAME FIRST Susie MIDDLE Pearl LAST Smith | | | 16. STREET ADDRESS 5808 Temple Hills | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 578 10 0541 | | 17. INFORMANT Roberta Bennsky | | 18. ADDRESS 5808 Temple Hills | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS | |
| 431- DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED ARTERIOSCLEROSIS | | | | | | | | 5 YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 19 1979 to 5/29 1980 , that (I) (we) last saw the deceased alive on 5/29 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Bruno Kolega</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/30/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUNO KOLEGA, MD | | | 22e. ADDRESS 4400 STAMP RD - TEMPLE HILLS, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 31 May 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Suitland, Md. | | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1980 | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 0 1 3 5 6 8 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA E. JACKSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 24, 1980 | | | 2b. HOUR 5:50 AM | |
| 3. SEX F | | 4. RACE N | | 5. DATE OF BIRTH MONTH DAY YEAR May 20 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9601 Annapolis Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James W. Williams | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Green | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Agnese Tate | | 17. ADDRESS 902 Alabama Ave SE, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1889 Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cerebral thrombosis | | | | | | | | | |
| 19a. DATE OF OPERATION 5/14/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral thrombosis | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/20/80 to 5/24/80, that (I) (we) last saw the deceased alive on 5/20/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frederick H. Wilhelm | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/24/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick H. Wilhelm | | 22e. ADDRESS 5507 Annapolis Road | | 22f. CITY OR TOWN Highland Rte. P.G. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 5-24-80 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony | | 23d. LOCATION CITY OR TOWN COUNTY STATE Highland Rte. P.G. MD | | | |
| 24. FUNERAL DIRECTOR NAME H.S. Washington-Sons | | | | 492 ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE | |

1. The first part of the report deals with the general situation of the company and the results of the work done during the year. It is a summary of the work done and the results achieved. It is a summary of the work done and the results achieved.

2. The second part of the report deals with the financial results of the company. It shows the income and expenses of the company and the profit or loss for the year. It is a summary of the financial results of the company.

3. The third part of the report deals with the management of the company. It shows the policies and procedures of the company and the results of the management. It is a summary of the management of the company.

4. The fourth part of the report deals with the future of the company. It shows the plans and objectives of the company for the future. It is a summary of the future of the company.

5. The fifth part of the report deals with the conclusion of the report. It is a summary of the work done and the results achieved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 3 5 6 9 | |
|---|---|--|--|---|---|---|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) Grace L. JOHNSON | | | | 2a DATE OF DEATH MONTH DAY YEAR May 6, 1980 | | 2b HOUR 10:00 A M |
| 3 SEX Female | 4 RACE Negro | 5 DATE OF BIRTH MONTH DAY YEAR Mar 7, 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 years YRS | # UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD | | |
| 10 CITY OR TOWN OF DEATH Glenn Dale | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maid | | 12b KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D. C. | | 13b COUNTY Washington | 13c CITY OR TOWN Washington | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS 5309 Colorado Avenue, N.W. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Not Stated | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Stated | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 578-14-4865 | | 17 INFORMANT ADDRESS Washington, DC, NW Kathryn Lewis, Daughter, 5309 Colorado Avenue | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary arteriosclerosis 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis; diabetes mellitus | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 23 19 75 to May 6 19 80 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 6 19 80 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death | | | | | | |
| 22b SIGNATURE <i>James W. Wills, M.D.</i> | | | | DEGREE | | 22c DATE SIGNED May 6, 1980 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D. | | | | 22e ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769 | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 9 May 80 | | 23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Bladensburg, P. G. Co., Md. |
| 24 FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc., Washington, D.C. | | | | 25 DATE REC'D BY REGISTRAR MAY 20 1980 | | 26 REGISTRAR'S SIGNATURE <i>Kathryn Lewis</i> |



| Name | | Address | | City | | State | | Zip | |
|--------------------|--|-------------------|--|-----------------|--|------------|--|-------|--|
| Mr. J. B. Smith | | 123 Main St. | | New York | | New York | | 10001 | |
| Mrs. A. C. Jones | | 456 Elm St. | | Los Angeles | | California | | 90001 | |
| Mr. R. D. White | | 789 Oak St. | | Chicago | | Illinois | | 60601 | |
| Ms. E. F. Green | | 321 Pine St. | | Houston | | Texas | | 77001 | |
| Mr. G. H. Black | | 654 Maple St. | | Phoenix | | Arizona | | 85001 | |
| Mrs. I. K. Brown | | 987 Cedar St. | | San Antonio | | Texas | | 78101 | |
| Mr. L. M. Davis | | 101 Birch St. | | Dallas | | Texas | | 75201 | |
| Ms. N. O. Miller | | 202 Spruce St. | | Portland | | Oregon | | 97201 | |
| Mr. P. Q. Wilson | | 303 Ash St. | | San Diego | | California | | 92101 | |
| Mrs. R. S. Moore | | 404 Hickory St. | | Austin | | Texas | | 78701 | |
| Mr. T. U. Taylor | | 505 Walnut St. | | Fort Worth | | Texas | | 76101 | |
| Ms. V. W. Anderson | | 606 Chestnut St. | | El Paso | | Texas | | 79901 | |
| Mr. X. Y. Jackson | | 707 Poplar St. | | Memphis | | Tennessee | | 38101 | |
| Mrs. Z. A. Roberts | | 808 Sycamore St. | | Nashville | | Tennessee | | 37201 | |
| Mr. B. C. Evans | | 909 Magnolia St. | | Birmingham | | Alabama | | 35201 | |
| Ms. D. E. Harris | | 1010 Dogwood St. | | Atlanta | | Georgia | | 30301 | |
| Mr. F. G. King | | 1111 Redwood St. | | Jacksonville | | Florida | | 32201 | |
| Mrs. H. I. Lee | | 1212 Cypress St. | | Tampa | | Florida | | 33601 | |
| Mr. J. K. Scott | | 1313 Juniper St. | | Orlando | | Florida | | 32801 | |
| Ms. L. M. Adams | | 1414 Willow St. | | Fort Lauderdale | | Florida | | 33301 | |
| Mr. N. O. Baker | | 1515 Birch St. | | Miami | | Florida | | 33101 | |
| Mrs. P. Q. Carter | | 1616 Spruce St. | | Hialeah | | Florida | | 33001 | |
| Mr. R. S. Evans | | 1717 Ash St. | | Coral Gables | | Florida | | 33134 | |
| Ms. T. U. Foster | | 1818 Hickory St. | | Doral | | Florida | | 33126 | |
| Mr. V. W. Gibson | | 1919 Walnut St. | | Kissimmee | | Florida | | 34741 | |
| Mrs. X. Y. Hall | | 2020 Poplar St. | | Winter Springs | | Florida | | 32789 | |
| Mr. Z. A. Young | | 2121 Sycamore St. | | Deerfield Beach | | Florida | | 33442 | |
| Ms. B. C. Allen | | 2222 Magnolia St. | | Palm Beach | | Florida | | 33480 | |
| Mr. D. E. Wright | | 2323 Dogwood St. | | West Palm Beach | | Florida | | 33411 | |
| Mrs. F. G. Lopez | | 2424 Redwood St. | | Boca Raton | | Florida | | 33433 | |
| Mr. H. I. Hill | | 2525 Cypress St. | | Delray Beach | | Florida | | 33484 | |
| Ms. J. K. Green | | 2626 Juniper St. | | Fort Pierce | | Florida | | 34946 | |
| Mr. L. M. Baker | | 2727 Willow St. | | Vero Beach | | Florida | | 34987 | |
| Mrs. N. O. Carter | | 2828 Birch St. | | Sebastian | | Florida | | 32976 | |
| Mr. P. Q. Evans | | 2929 Spruce St. | | Titusville | | Florida | | 32780 | |
| Ms. R. S. Foster | | 3030 Ash St. | | Melbourne | | Florida | | 32901 | |
| Mr. T. U. Gibson | | 3131 Hickory St. | | Palm Bay | | Florida | | 32909 | |
| Mrs. V. W. Hall | | 3232 Walnut St. | | Satellite Beach | | Florida | | 32907 | |
| Mr. X. Y. Allen | | 3333 Poplar St. | | Maitland | | Florida | | 32751 | |
| Ms. Z. A. Wright | | 3434 Sycamore St. | | Winter Park | | Florida | | 32789 | |
| Mr. B. C. Lopez | | 3535 Magnolia St. | | Lake Wales | | Florida | | 33854 | |
| Mrs. D. E. Hill | | 3636 Dogwood St. | | Dunnellon | | Florida | | 33827 | |
| Mr. F. G. Scott | | 3737 Redwood St. | | Hawthorne | | Florida | | 33427 | |
| Ms. H. I. Adams | | 3838 Cypress St. | | Lakeland | | Florida | | 33801 | |
| Mr. J. K. Baker | | 3939 Juniper St. | | Winter Haven | | Florida | | 33884 | |
| Mrs. L. M. Carter | | 4040 Willow St. | | Auburndale | | Florida | | 33886 | |
| Mr. N. O. Evans | | 4141 Birch St. | | Ocala | | Florida | | 33455 | |
| Ms. P. Q. Foster | | 4242 Spruce St. | | Gainesville | | Florida | | 32601 | |
| Mr. R. S. Gibson | | 4343 Ash St. | | Lehigh | | Florida | | 33901 | |
| Mrs. T. U. Hall | | 4444 Hickory St. | | Bradenton | | Florida | | 34201 | |
| Mr. V. W. Allen | | 4545 Walnut St. | | Palmdale | | California | | 93551 | |
| Ms. X. Y. Wright | | 4646 Poplar St. | | Lancaster | | California | | 93534 | |
| Mr. Z. A. Lopez | | 4747 Sycamore St. | | Palmdale | | California | | 93551 | |
| Mrs. B. C. Hill | | 4848 Magnolia St. | | Lancaster | | California | | 93534 | |
| Mr. D. E. Scott | | 4949 Dogwood St. | | Palmdale | | California | | 93551 | |
| Ms. F. G. Adams | | 5050 Redwood St. | | Lancaster | | California | | 93534 | |
| Mr. H. I. Baker | | 5151 Cypress St. | | Palmdale | | California | | 93551 | |
| Mrs. J. K. Carter | | 5252 Juniper St. | | Lancaster | | California | | 93534 | |
| Mr. L. M. Evans | | 5353 Willow St. | | Palmdale | | California | | 93551 | |
| Ms. N. O. Foster | | 5454 Birch St. | | Lancaster | | California | | 93534 | |
| Mr. P. Q. Gibson | | 5555 Spruce St. | | Palmdale | | California | | 93551 | |
| Mrs. R. S. Hall | | 5656 Ash St. | | Lancaster | | California | | 93534 | |
| Mr. T. U. Allen | | 5757 Hickory St. | | Palmdale | | California | | 93551 | |
| Ms. V. W. Wright | | 5858 Walnut St. | | Lancaster | | California | | 93534 | |
| Mr. X. Y. Lopez | | 5959 Poplar St. | | Palmdale | | California | | 93551 | |
| Mrs. Z. A. Hill | | 6060 Sycamore St. | | Lancaster | | California | | 93534 | |
| Mr. B. C. Scott | | 6161 Magnolia St. | | Palmdale | | California | | 93551 | |
| Ms. D. E. Adams | | 6262 Dogwood St. | | Lancaster | | California | | 93534 | |
| Mr. F. G. Baker | | 6363 Redwood St. | | Palmdale | | California | | 93551 | |
| Mrs. H. I. Carter | | 6464 Cypress St. | | Lancaster | | California | | 93534 | |
| Mr. J. K. Evans | | 6565 Juniper St. | | Palmdale | | California | | 93551 | |
| Ms. L. M. Foster | | 6666 Willow St. | | Lancaster | | California | | 93534 | |
| Mr. N. O. Gibson | | 6767 Birch St. | | Palmdale | | California | | 93551 | |
| Mrs. P. Q. Hall | | 6868 Spruce St. | | Lancaster | | California | | 93534 | |
| Mr. R. S. Allen | | 6969 Ash St. | | Palmdale | | California | | 93551 | |
| Ms. T. U. Wright | | 7070 Hickory St. | | Lancaster | | California | | 93534 | |
| Mr. V. W. Lopez | | 7171 Walnut St. | | Palmdale | | California | | 93551 | |
| Mrs. X. Y. Hill | | 7272 Poplar St. | | Lancaster | | California | | 93534 | |
| Mr. Z. A. Scott | | 7373 Sycamore St. | | Palmdale | | California | | 93551 | |
| Ms. B. C. Adams | | 7474 Magnolia St. | | Lancaster | | California | | 93534 | |
| Mr. D. E. Baker | | 7575 Dogwood St. | | Palmdale | | California | | 93551 | |
| Mrs. F. G. Carter | | 7676 Redwood St. | | Lancaster | | California | | 93534 | |
| Mr. H. I. Evans | | 7777 Cypress St. | | Palmdale | | California | | 93551 | |
| Ms. J. K. Foster | | 7878 Juniper St. | | Lancaster | | California | | 93534 | |
| Mr. L. M. Gibson | | 7979 Willow St. | | Palmdale | | California | | 93551 | |
| Mrs. N. O. Hall | | 8080 Birch St. | | Lancaster | | California | | 93534 | |
| Mr. P. Q. Allen | | 8181 Spruce St. | | Palmdale | | California | | 93551 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | |
|---|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CECELIA S. JONES | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 30 80 | | | 2b. HOUR 3:20A M | | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR March 7, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY P.G. Co. | | 13c. CITY OR TOWN District Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7214 Kipling Parkway | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John - Searles | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude - Whiteside | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None | | 17 INFORMANT Sandra Jones (Daughter) | | ADDRESS Same as # 13. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac and Pulmonary failure 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) malignant pleural effusion and DUE TO, OR AS A CONSEQUENCE OF (c) advance Ca of the breast (L.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-29 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-29 19 80 , to 5-30 19 80 , that (I) (we) last saw the deceased alive on 5-29 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE SAID A. DAE | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 5-30-80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAID A. DAE | | | | | 22e. ADDRESS Prince George | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 6/2/80 | | 23c. NAME OF CEMETERY OR CREMATORY Seaside Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Palermo, Cape May Co., Maryland | | | | |
| 24 FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | | ADDRESS Riverdale, Maryland | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 5 7 1 | | | |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edna F. JONES | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 18, 1980 | | 2b. HOUR 8:15 M | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR MAY 10, 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD | |
| 10 CITY OR TOWN OF DEATH Glenn Dale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC WORK | | 12b. KIND OF BUSINESS OR INDUSTRY PVT | |
| 13a. STATE D.C. | | 13b. COUNTY N/A | | 13c. CITY OR TOWN WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST CHARLES M. DAVIS | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE ALTON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO 579 16 2032 | | 17 INFORMANT MARIE WASHINGTON SISTER | | | | ADDRESS 5901 EAST CAPITOL ST S.E. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| 438- CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST DUE TO, OR AS A CONSEQUENCE OF (b) Old cerebrovascular accident w/left hemi-paresis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) disease. Chronic brain syndrome w/seizure disorder; Hypertensive cerebrovascular heart | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 31 , 19 78 , to May 18 , 19 80 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 18 , 19 80 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE James W. Wills M.D. | | | | DEGREE | | 22c. DATE SIGNED May 18, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D. | | | | 22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 22, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MD | |
| 24 FUNERAL DIRECTOR NAME ALEXANDER S. POPE | | | | 25 DATE REC'D. BY REGISTRAR MAY 26 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i> | |

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May 12, 1902

May 10, 1902

Prince George County

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

Chronic brain syndrome; hypertensive cerebrovascular heart disease.

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

May 10, 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|------------------------------|
| 1- FOR STATE REGISTRAR | | | | | 8 0 1 3 5 7 2 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN WILLIAM KINNAIRD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 24 80 | | | | | 2b. HOUR 4:20 A.M. |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR December 5, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH College Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4612-Beechwood Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) English Professor | | 12b. KIND OF BUSINESS OR INDUSTRY University of Maryland | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4612-Beechwood Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Kinnaird | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kurkinen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Joan Kennedy Kinnaird (Wife) Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1552 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PNEUMONIA (c) CARCINOMA OF LIVER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 7 MO | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) WIDESPREAD METASTASES - POST OP FROM 2 CRANIOTOMIES | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22 , 19 80 , to 5/24 , 19 80 , that (I) (we) last saw the deceased alive on 5/22 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. SIGNATURE Richard P. Delaney, MD | | | | | DEGREE MD | | | 22c. DATE SIGNED 5/24/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY, MD | | | | | 22e. ADDRESS 4323 HAVARD ST. SIL. SPR. MD 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-28-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cold Spring Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cold Spring, New York | | | | |
| 24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. | | | | | ADDRESS 300-4th St., NE, Wash., D.C. | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE L. J. McBrady | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 3 5 7 3 | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) ASTRID JOHNSON KLEIN | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 21 1980 | | | 2b. HOUR 12:16 PM | | | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 9 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 | | 7 IF UNDER 1 YEAR MONTHS DAYS YRS. | | 8 IF UNDER 24 HRS HOURS MIN YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | 13b CITY OR TOWN PRINCE GEO | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS 5609 KENWOOD STREET | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST NELS JOHNSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA CHRISTALIA ANDERSON | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 263-78-5848 | | 17 INFORMANT ADDRESS LINNEA DITTMAR 5609 KENWOOD ST CAMP SPRINGS | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 19 May 1980 to 21 May 1980 , that (I) (we) last saw the deceased alive on 21 May 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Kevin B. St. John | | | | DEGREE | | | | 22c DATE SIGNED 21 May 80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN B. ST JOHN, CAPT, USAF, MC | | | | 22e ADDRESS MG USAF MC AAFB, MD 20331 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE 5/24/80 | | 23c NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | | | | | |
| 24 FUNERAL DIRECTOR NAME Lee Funeral Home Inc. | | | | | | 25a DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b REGISTRAR'S SIGNATURE Anthony McCreedy | | | |
| 633 Old Alexander Ferry Road Clinton Md. | | | | | | | | | | | |

6033 111 Alexander Road (London N.Y.)
The Funeral Home Inc.
Green Lion 3/25/80 Joe's Crematory
Washington D.C.

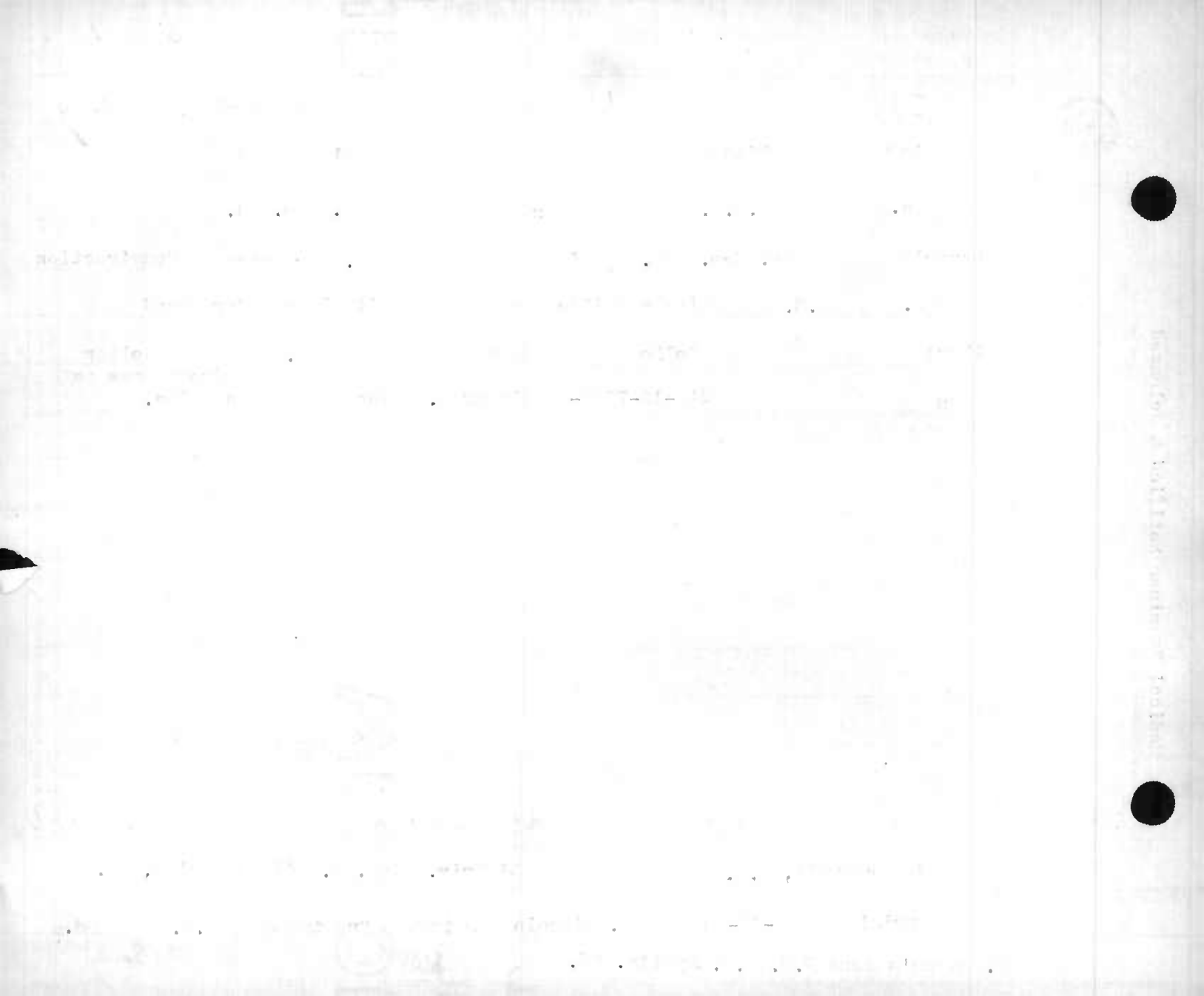
Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|---|--|--|--|----------------------------|--|----------------------|--|
| 1- FOR STATE REGISTRAR | | | | | 8 0 1 3 5 7 4 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| John W. Kolbe Sr. | | | | | 5-23-80 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Male | | White | | 2/18/1899 | | 81 | | 9:25 A.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Pa. | | U.S.A. | | | | Pr. Geo. Co. | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | Pr. Geo. Gen. Hospital | | | | Ret. Carpenter | | Construction | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Md. | | | | | P.G. | | Mitchellville | | 11201 Lottsford Road | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Albert Kolbe | | | | | Emma J. Weller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | | | | 212-12-7788-A | | Gladys I. Kolbe | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest | | | | | 5 min. | | | | | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable myocardial infarction | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 2 Large Decubiti on Buttocks with Sepsis. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 to MAY 1980, that (I) (we) lost saw the deceased alive on 5/12/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| David Cromwell M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 5/23/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| David Cromwell, M.D. | | | | | 831 Univ. Blvd. E. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | 5-27-80 | | Ft. Lincoln Cemetery | | Brentwood P.G. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | | MAY 26 1980 | | Dorothy McBrady | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 3 5 7 5 |
|--|--|--|--|--|--|---|--|--|--|---------------|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG NO |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONSTANCE LAWS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 27 80 | | 2b. HOUR 5 P M | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 3 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4011 Denfield Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY ROBINSON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Margaret Field Rt.#2 Box 257 Bealeton, Virginia | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (b) asphyxia DUE TO, OR AS A CONSEQUENCE OF: (c) metastatic carcinoma carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 5 1/2 | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/12/ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subtotal Obstruction | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/27/ 19 80 to 5/27/ 19 80 , that (I) (we) lost saw the deceased alive on 5/27 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE (SPECIFY) H. L. MARTEO | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED June 2, 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. MARTEO | | 22e. ADDRESS 531 University Blvd E. 9th | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5/30/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE Johny McRaney | | | | |

MEDICAL CERTIFICATION

2
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44

35

150

2

2

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1

BP

3502

James George

x

own wife

4011 Oxford Avenue

Montgomery

Montgomery, Ala. 36102
Box 247

10

James George, 4011 Oxford Avenue, Montgomery, Ala. 36102

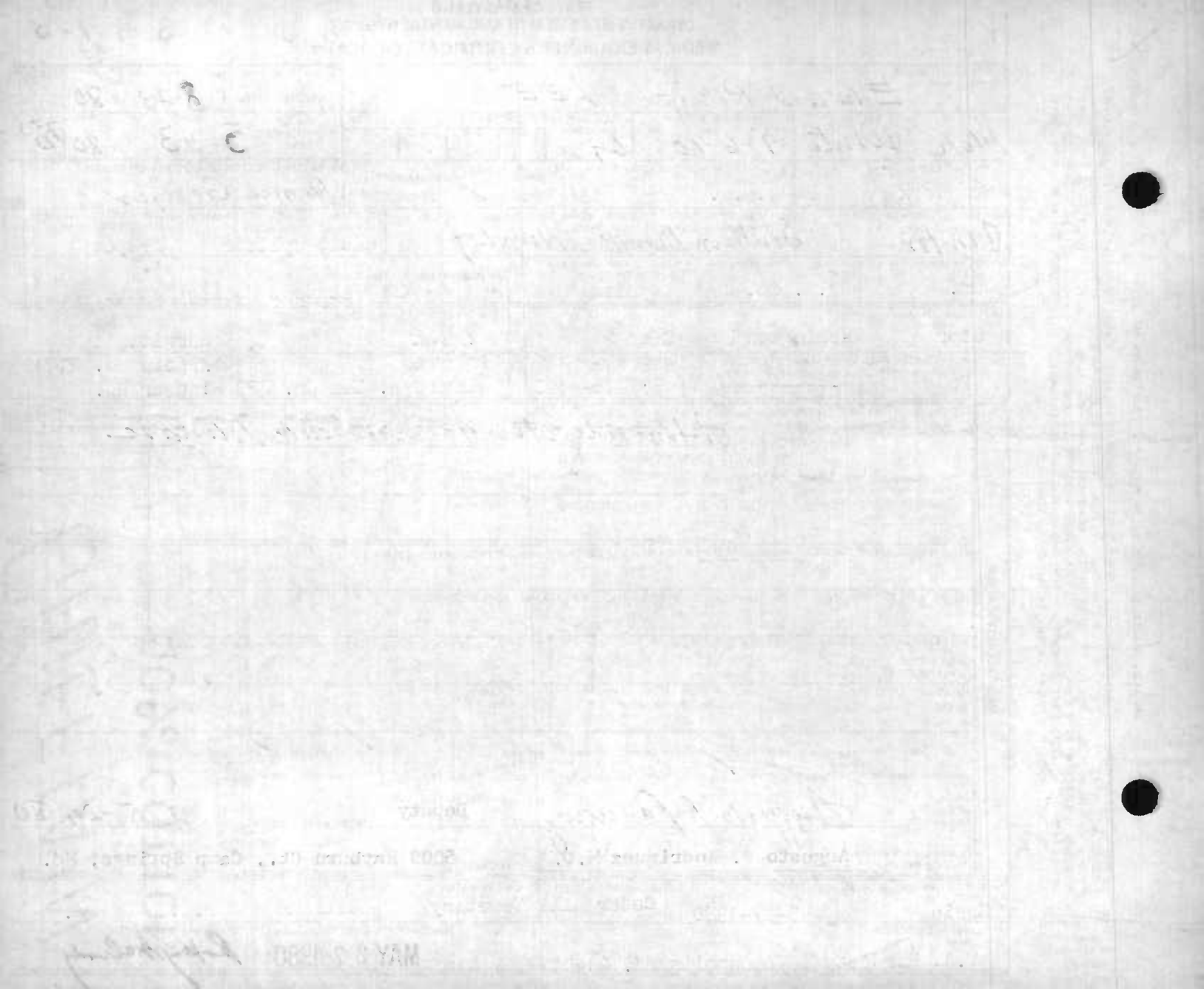
James George, 4011 Oxford Avenue, Montgomery, Ala. 36102

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|--------------------------|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Edward Robert | | LEE | | | | | | MONTH DAY YEAR | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7c. DATE PRONOUNCED DEAD | | 24. HOUR | |
| Male | | White | | MONTH DAY YEAR | | LAST BIRTHDAY YRS. | | MONTH DAY YEAR | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New York | | u.s.a. | | NEVER MARRIED | | Prince Georges | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Clinton | | Southern Maryland Hospital | | Cable Splicer | | Pepco | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | |
| Md. | | A.A. Co. | | Lothian | | YES NO | | Patuxent Mobile Estate | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| George Washington | | Sarah Merritt | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 577-16-4793 | | Edward R. Lee Jr. | | Arnold Md. 21012 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. AUTOPSY? | | | | | | | |
| 4292 | | Antenatal vascular disease | | YES NO | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | |
| | | | | YES NO | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy | | Inspection | | Inquiry | | and in my opinion | | | |
| death resulted from: | | Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | |
| Augusto P. Rodriguez | | Deputy | | | | 5-24-80 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Augusto P. Rodriguez M.D. | | 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | |
| Burial | | 5-27-1980 | | Cedar Hill Cemetery | | Suitland | | P.G. | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| T.A. Hardesty | | Annapolis Md. 21401 | | MAY 27 1980 | | Anthony McCreedy | | | | | |



RELEASED BY MEDICAL COUNCIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Robert H. Lee | | 2a. DATE OF DEATH MONTH DAY YEAR 5-6-80 | | 2b. HOUR 10:35 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2-29-28 | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | |
| 10. CITY OR TOWN OF DEATH Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent | 12b. KIND OF BUSINESS OR INDUSTRY Auto | | |
| 13a. STATE Md. COUNTY P.G. | | 13b. CITY OR TOWN Clinton | 13c. STREET ADDRESS 6201 Woodland Lane | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Warren H. Lee Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby M. Coffey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-35-4818 | | 17. INFORMANT ADDRESS Irma T. Lee (Wife) Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 |
| 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) Severe Carotid-Vascular Atherosclerosis | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) Ageing & Decease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10-19-69 to 5-6-19-80 , that (I) (we) lost saw the deceased alive on 4-9-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Richard H. Dobson | | DEGREE | | 22c. DATE SIGNED 5-6-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Dobson | | 22e. ADDRESS Brandywine Medical Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/9/80 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | |
| 23d. LOCATION CITY OR TOWN Clinton | | 23e. COUNTY P.G. | | 23f. STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. | | ADDRESS 6633 Old Alexander Ferry Road Clinton Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1980 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

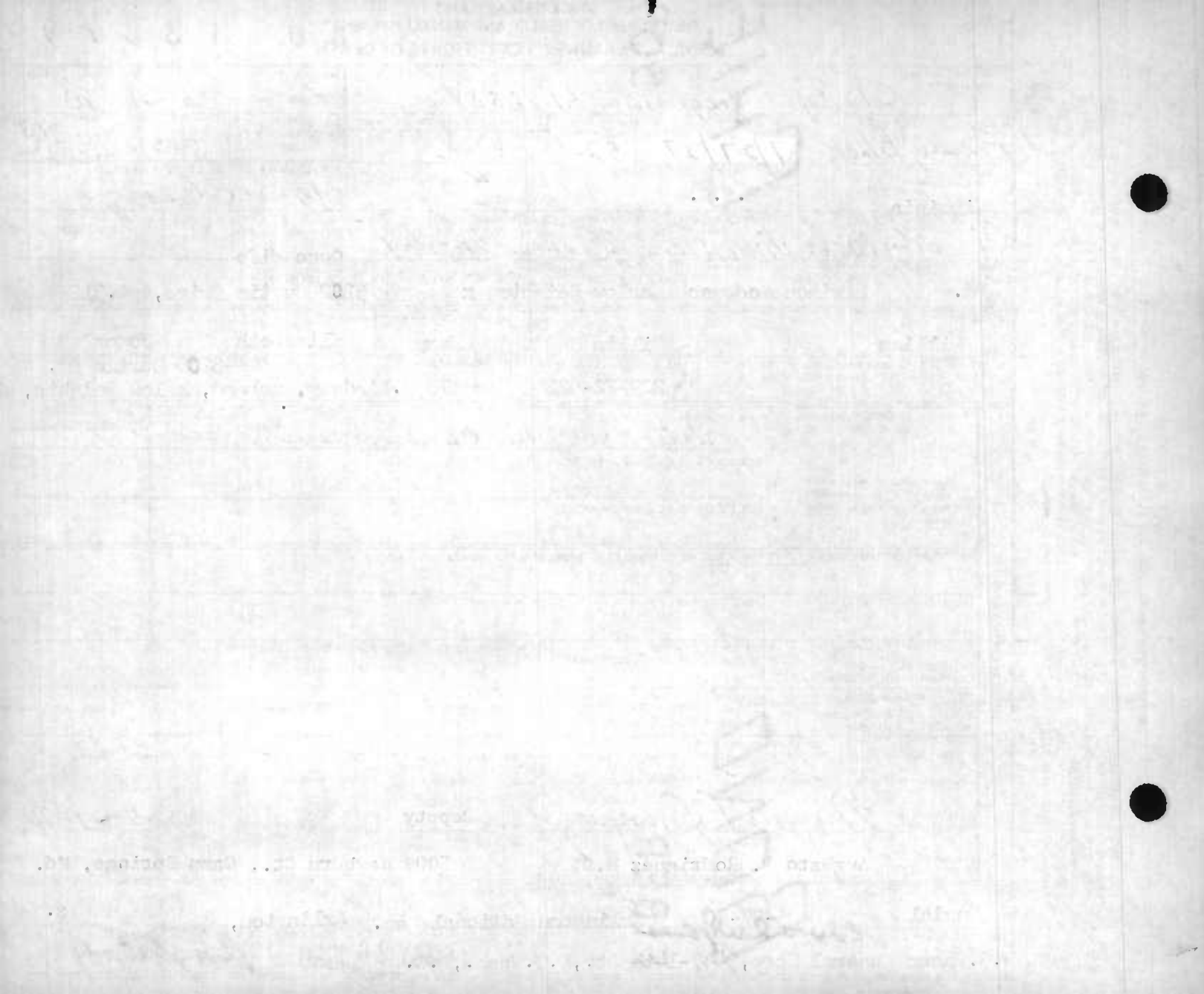
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST HEINZ PAUL LEIBE | | | | | MONTH DAY YEAR MAY 8 1980 | | | | |
| 3 SEX | | | | | 4 RACE | | | | |
| Male | | | | | White | | | | |
| 5 DATE OF BIRTH | | | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR March 2, 1925 | | | | | 55 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Germany | | | | | U.S.A. | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Lanham | | | | | Doctors' Hosp. of Pr. Geo. Co. | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Account Exec. | | | | | W.G.L. Co. | | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | | | |
| Md. | | | | | P.G. | | | | |
| 13c. INSIDE CITY LIMITS? | | | | | 13d. STREET ADDRESS | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 5801 Bucknell Terrace | | | | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Kurt F. Leibe | | | | | FIRST MIDDLE LAST Margaret Pflugrad | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| Yes | | | | | W.W. II 579-20-5234 | | | | |
| 17 INFORMANT | | | | | ADDRESS | | | | |
| Margaret W. Leibe | | | | | Address Same as No # 13e. | | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular rupture</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic obstructive airway disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>80</u> , to <u>5-8</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | |
| V.P.S. M.D. | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 4/8/80 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| Virender P. Singh, M.D. | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| 3700 East-West Highway, Hyattsville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| Burial | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 5-12-80 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Gate of Heaven Cemetery Silver Spring Montgomery, Md. | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | | | | | |
| 25a. DATE REC'D BY REGISTRAR | | | | | | | | | |
| MAY 13 1980 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| [Signature] | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 80-13579 | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Gladys Virginia LINDSAY | | | | | | 2c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11-17-25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 7. DATE KNOWN OF DEATH | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly (MD) | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | | 13. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Marlow Heights | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3202 Curtis Drive, Apt. 312 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Willis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Jones | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 229-22-0224 | | 17. INFORMANT ADDRESS 3208 Curtis Dr. Ronald S. Lindsay, Husband, Marlow Heights, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. T9 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5-27-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-27-80 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va. | | | |
| 24. FUNERAL DIRECTOR NAME H.W. Bacon | | | | ADDRESS 3447-14th St., N.W. Wash., D.C. | | 25. DATE REC'D. BY REGISTRAR MAY 26 1980 | | 26. REGISTRAR'S SIGNATURE <u>Robert M. Kelly</u> | | | |

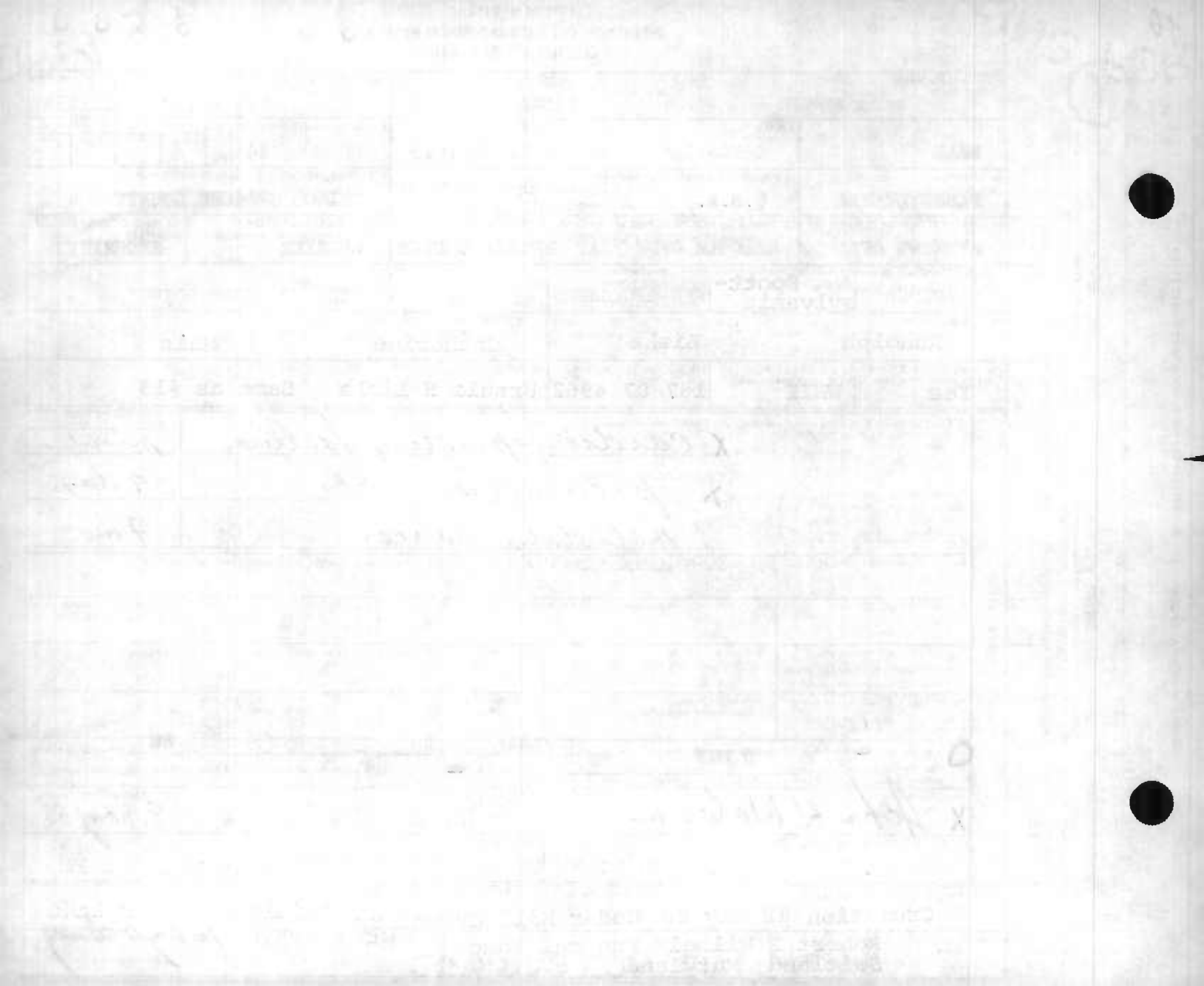


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--------------------------|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| JOSEPH LISK A | | | MAY 9 1980 | | | 12:15A | | | M |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | |
| MALE | | CAUCASIAN | | DECEMBER 25 1915 | | 64 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | | | PRINCE GEORGES COUNTY MD | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| ANDREWS AFB | | MALCOLM GROW USAF MEDICAL CENTER | | | | COURIER | | SECURITY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTRY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| VIRGINIA | | sylvania | | FREDRICKSBURG | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4224 WOODSIDE DRIVE | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Rudolph Liska | | | Catherine Mais | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | |
| Yes | | WWII | | 167 07 4962 | | Ursula H Liska Same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>pneumonia</u> | | | | | | | | minutes | |
| (c) <u>metastatic cancer</u> | | | | | | | | 4 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | 7 mo | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 21g. I certify that (this hospital) attended the deceased from <u>28 APRIL</u> , 19 <u>80</u> , to <u>9 MAY</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>9 MAY</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a SIGNATURE <u>John H Wales</u> | | | | DEGREE | | 22b. DATE SIGNED | | | |
| | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 9 May 80 | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS | | | | | |
| JOHN H. WALES, CAPT, USAF, MC | | | | MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 12 May 80 | | Cedar Hill Crematory | | Suitland Maryland | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. SIGNATURE | | | |
| Robert E Wilhelm | | Funeral Home | | MAY 14 1980 | | [Signature] | | | |
| Suitland Maryland | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13581

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|---------|---|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH DAY YEAR | | 2b. HOUR | |
| Mary Agnes | | LOHR | | 5-12 | | 1980 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | |
| Female | White | 3-5-94 | | 86 | | MONTHS DAYS HOURS MIN. | | | | 5-12 1980 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| District of Columbia | | USA | | WIDOWED | | DIVORCED | | Prince Georges | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Hyattsville | | Sacred Heart Home | | Examiner-Bur. of Engraving & Printing | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | |
| Maryland | | Prince-Georges | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5115 Woodland Blvd | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| Robert Phelps | | Margaret Allen | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 577-12-7112 | | Jeannette Cantwell | | 2563 Forest Knoll | | | | | |
| | | | | | | Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| 2507 Death of myocardial conduction disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| Left hip pinning, osteoporosis, decubitus ulcers. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 2 (P.M.) | | 3-26 1980 | | Accidental | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| | | Nursing Home | | 5805 Queens Chapel Rd., Hyattsville, Pr. Georges | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Augusto P. Rodriguez M.D. | | Deputy | | 5-12-80 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Augusto P. Rodriguez M.D. | | 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | |
| Burial | | 14 May 1980 | | Mt Olivet Cemetery | | Washington, | | | | D.C. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert E. Wilhelm | | Suitland, Md. | | MAY 19 1980 | | History McCreedy | | | | | |

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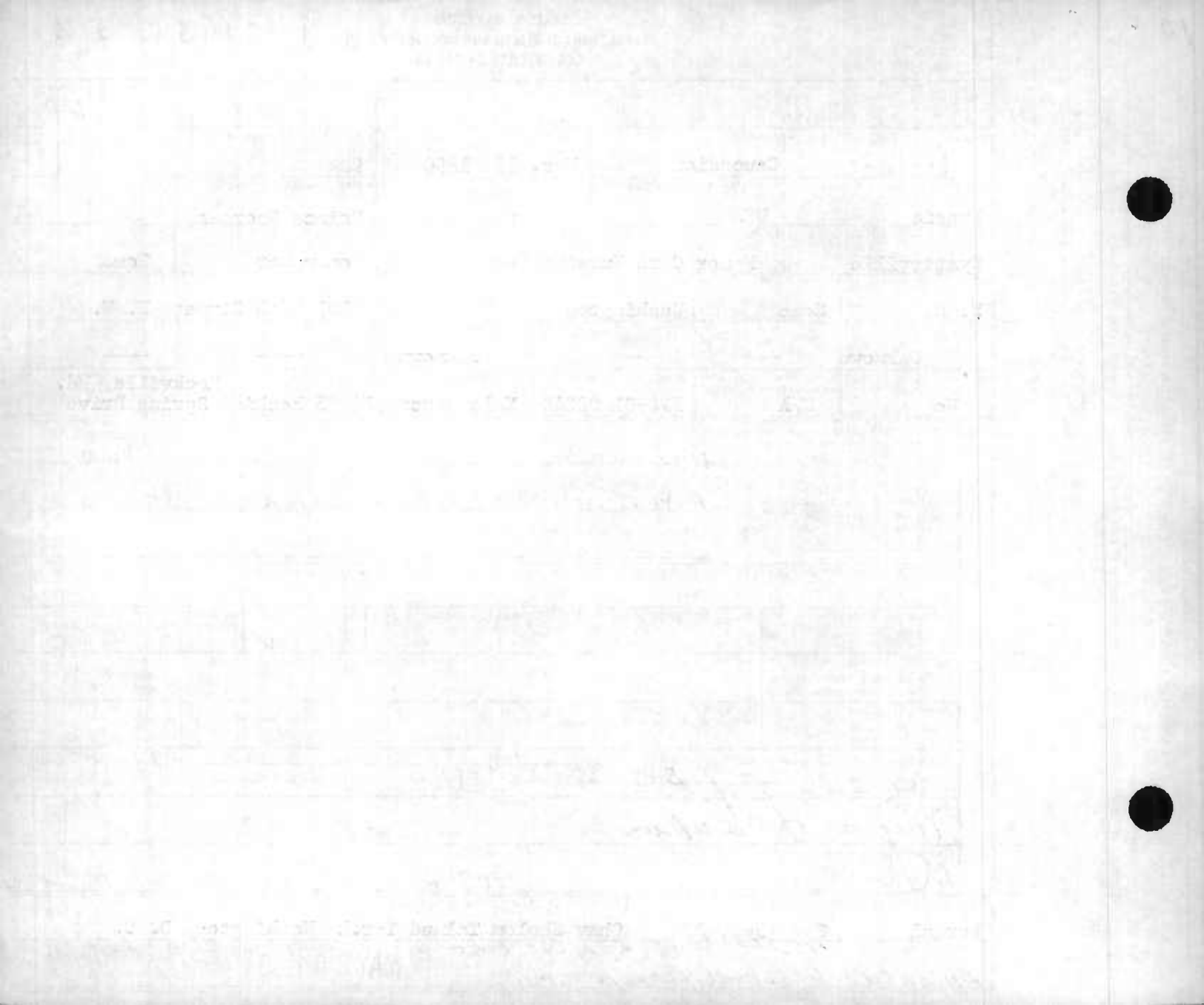
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Anna</u> <u>Lucks</u> | | | | | 2a DATE OF DEATH MONTH DAY YEAR <u>5-19-80</u> | | | 2b HOUR <u>6 P</u> M | |
| 3 SEX <u>Female</u> | | 4 RACE <u>Caucasian</u> | | 5 DATE OF BIRTH MONTH DAY YEAR <u>Mar. 18, 1890</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Russia</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince Georges</u> MD | | | |
| 10 CITY OR TOWN OF DEATH <u>Hyattsville</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Manor Care Nursing Home</u> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>D. C.</u> | | 13b COUNTY <u>None</u> | | 13c CITY OR TOWN <u>Washington</u> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS <u>6101 16th Street, N. W.</u> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <u>Unknown</u> --- --- | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Unknown</u> --- --- | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>N/A</u> | | 17 INFORMANT ADDRESS <u>Rockville, Md.</u> <u>Yale Marcus, 14905 Rocking Spring Drive</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4370</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9-6</u> , 19 <u>79</u> , to <u>5-19</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-19</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Myron L Lenkin</u> DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Myron L Lenkin</u> | | | | | 22e. ADDRESS <u>2309 Shorefield Rd. Wheaton, Md. 20902</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5-20-80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ohev Shalom Talmud Torah</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D. C.</u> | | | |
| 24 FUNERAL DIRECTOR NAME <u>DANZANSKY GOLDBERG, ROCKVILLE, MD</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 26 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>Anthony J. Cassidy</u> | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13583 | |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH FRANK MACALUSO | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 5-29 19 80 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 DAY 3 YEAR 19 | | 6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MAY 29 19 80 11:07 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD | |
| 10. CITY OR TOWN OF DEATH Lanham | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Microbiologist | | 12b. KIND OF BUSINESS OR INDUSTRY U.S.D.A. | |
| 13a. STATE Maryland | | | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN GLEnn Dale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11309 Daisey Lane | |
| 14. FATHER'S NAME FIRST Salvatore MIDDLE Macaluso LAST Macaluso | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Angeline MIDDLE Cali LAST Cali | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 1944-1946 | | 17. INFORMANT Eleanor M. Macaluso Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarctus subacute Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED May 30, 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6-3-80 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR JUN 10 1980 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| 16,000 Annapolis Rd. Bowie, Md. | | | | | | | | | | | |

Pennsylvania U.S.A.

Microbiologist U.S.D.A.

| | | | | | | | | | |
|-----|-----------|---|-----------|----------|----------|------|------------------|-------------------|------------|
| Yes | 1944-1946 | 028-12-2276 Eleanor W. Macaluso same as A. 13 | Salvatore | Macaluso | Angeline | Call | 11309 Daisy Lane | Maryland Rt. Geo. | Glenn Dale |
|-----|-----------|---|-----------|----------|----------|------|------------------|-------------------|------------|

16,000 Annapolis Rd. Bowie, Md.
Beall Funeral Home
6-3-80 Md. Veterans Cem. Cheltenham Rt. Geo. Md.
Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 3 0 1 3 5 8 4 | |
|---|--|--|---|---|---|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) RUBY C. MacLEAN | | | 2a. DATE OF DEATH MONTH 5 DAY 4 YEAR 80 11:15 P.M. | | |
| 3 SEX Female | 4 RACE CAUCASIAN | 5. DATE OF BIRTH MONTH 10 DAY 30 YEAR 1898 | | 6. AGE (IN YRS. LAST BIRTHDAY) 91 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA | 7b CITIZEN OF WHAT COUNTRY? US | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | |
| 10 CITY OR TOWN OF DEATH LARGO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE LARGO | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY not known |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia 13b. COUNTY Fairfax 13c. CITY OR TOWN Burke | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST WILLIAM MIDDLE HUNT LAST HUNT | | | 15 MOTHER'S MAIDEN NAME FIRST CHARLOTTE MIDDLE EVANS LAST EVANS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 285-14-2295 | | 17 INFORMANT Angus B. MacLean ADDRESS 5925 Boothe Drive Burke, Virginia | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 1st , 19 78 , to May 4 , 19 80 , that (I) (we) last saw the deceased alive on April 17 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE W.P. Jones MD DEGREE | | | | 22c. DATE SIGNED May 4, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendy P. Jones-Kay MD | | | | 22e. ADDRESS 2601 Riverdale Road New | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5-5-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1980 | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W. Washington, D. C. 20016 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 | | Medical Examiner's Release | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) HOSSEIN MALEKZADEH | | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 14 80 | | 2b HOUR 10:15A.M. | |
| 3 SEX Male | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR 01 01 97 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN | | 7b CITIZEN OF WHAT COUNTRY? IRAN | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b KIND OF BUSINESS OR INDUSTRY Farming | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b CITY OR TOWN 13c INSIDE CITY LIMITS? Md. Charles Waldorf YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d STREET ADDRESS 20205A Wedgewood Place | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Mohammed Reza Malekzadeh | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Omeh unk. | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. none | | 17 INFORMANT ADDRESS Hooshang Malekzadeh(son) same as (13) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prob. acute Myocardial infarct + shock</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery dise</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u> | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/14/1980</u> to <u>5/14/1980</u> , that (I) (we) last saw the deceased alive on <u>5/14/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <u>P. Seshachary MD</u> | | | | DEGREE MD | | 22c DATE SIGNED 5-14-80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) P. SESHACHARY MD | | | | 22e ADDRESS Bldg 505, Charles Prop. Cent Waldorf MD 20685 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 5-19-1980 | | 23c NAME OF CEMETERY OR CREMATORY Beheslt Zahra | | 23d LOCATION CITY OR TOWN COUNTY STATE Tehran Iran | |
| 24 FUNERAL DIRECTOR NAME ADDRESS <u>John F. Dotal</u> 2222 Wisc. Ave., Wash. D.C. | | | | 25a DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b REGISTRAR'S SIGNATURE <u>John F. Dotal</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|------------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD C. MALLOY JR | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 07 80 | | 2b. HOUR 9:20 A.M. | | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 02 13 37 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Census Bur. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Prince Geo | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward C. Malloy, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Morris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-1963 | | 17. INFORMANT ADDRESS Mary P. Malloy same as 13c | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive infarction of small and large bowel.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mural thrombus of aortic valve and bicuspid valve.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Polycystic disease of kidney and hepatic cysts.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Polycystic disease of kidney and hepatic cysts.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION 4/24/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic valve replacement | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5. 6. 80</u> 19 <u>80</u> , to <u>5. 7. 80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-7-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Mridula Singh | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 5. 7. 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mridula Singh, M.D. | | | | 22e. ADDRESS 7503 Surratts Rd., Clinton, Md. 20735 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial - Transit | | 23b. DATE May 10 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St. Denis | | 23d. LOCATION CITY OR TOWN COUNTY STATE Havertown, Delaware Co., Pa. | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | | 25. DATE REC'D. BY REGISTRAR MAY 13 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |
| 25c. ADDRESS 16000 Annapolis Rd Bowie Md | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13587 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Howard Payne MARTIN</i> | | | | | | | | | | 7b. HOUR | |
| 3. SEX <i>Male</i> 4. RACE <i>Black</i> 5. DATE OF BIRTH <i>7-8-17</i> 6. AGE <i>62</i> YRS. 7c. DATE PRONOUNCED <i>5-12-80</i> | | | | | | | | | | 7d. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i> 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> | | | | | | | | | | 7d. HOUR | |
| 10. CITY OR TOWN OF DEATH <i>Chesley</i> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Prince Georges General Hospital</i> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i> 12b. KIND OF BUSINESS OR INDUSTRY <i>Navy Dept.</i> | | | | | | | | | | | |
| 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Prince Geo.</i> 13c. CITY OR TOWN <i>Landover</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>1101 Harley Road Apt 1017</i> | | | | | | | | | | | |
| 14. FATHER'S NAME <i>Edgar</i> 15. MOTHER'S MAIDEN NAME <i>Maude Webster</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> 16b. SOCIAL SECURITY NO. <i>238 18 8385</i> 17. INFORMANT <i>Gladys O. Hudson</i> 17a. ADDRESS <i>3800 Route 97 Glenwood, Maryland</i> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>Intense atherosclerotic cardiovascular disease</i> 4292 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Ethanol abuse</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER DATE SIGNED <i>5-13-80</i> | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i> 23b. DATE <i>5/15/80</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i> 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P.G. Md.</i> | | | | | | | | | | | |
| 24. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

Francis Gash's Sons Funeral Home, P.A.
Hyattsville, Maryland

MAY 13 1980

25b. REGISTRAR'S SIGNATURE
Robert McBratney



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

1 3 5 8 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Herman | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 14 80 | | | 2b. HOUR 2:40P M | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 8 29 45 | | 6 AGE (IN YEARS LAST BIRTHDAY) 34 YRS. | | 7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 34 | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD. | | | |
| 10 CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11938 Lime Kiln Road Fulton Md. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Otis Mauck | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Elizabeth Lissau | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT ADDRESS Mrs Otis Mauck 11938 Lime Kiln Rd 20759 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration pneumonia 3453 DUE TO, OR AS A CONSEQUENCE OF (b) Status, epileptic (clinical) DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Anu Kurichh | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5. 15. 80. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anu Kurichh, M.D. | | | | 22e. ADDRESS Cheverly, Maryland 20785 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 16, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St Pauls Lutheran | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fulton Maryland | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia RD ellicott City | | | | | | | | | |

MAY 25 1980

REGISTRAR'S SIGNATURE

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Handwritten notes and bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) THOMAS JOSEPH MCCARTHY | | | 2a. DATE OF DEATH MONTH DAY YEAR APRIL 30, 1980 | | | 2b. HOUR 5:40 A.M. | | | |
| 3 SEX MALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH MONTH DAY YEAR NOV 1, 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | |
| 10 CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF PR. GEO. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Projectionist | | 12b. KIND OF BUSINESS OR INDUSTRY Movie | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE Maryland | | 13b CITY OR TOWN Pr. Geo. | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS 2809 Buxmont Lane | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Francis McCarthy | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice E Sheehan | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a | | 17 INFORMANT ADDRESS Florence Hussey Same as # 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MID BRAIN INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MASSIVE GASTRO-INTESTINAL HEMMORRAGE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks 7 weeks 7 weeks | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Nov. 1976</u> to <u>4-30-1980</u> , that (I) (we) lost saw the deceased alive on <u>4-28-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <i>John Cosma, M.D.</i> | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 4/30/80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN COSMA, M.D. | | | | | 22e ADDRESS 6776 Race Track Road, Bowie, Md. | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 2 MAY 80 | | 23c NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Bowie Prince George's Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Beall Funeral Home 16000 Annapolis Rd. Bowie, Md. | | | | | 25 REGISTRATION DATE MAY 6 1980 REGISTRAR'S SIGNATURE <i>John Sullivan</i> | | | | |

1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the methods used, and a summary of the results obtained. The second part of the report is a detailed description of the work done on each project. It includes a description of the objectives of the project, a description of the methods used, and a description of the results obtained. The third part of the report is a summary of the conclusions reached from the work done during the year. It includes a list of the conclusions reached, a description of the methods used, and a summary of the results obtained. The fourth part of the report is a list of the references cited in the report. It includes a list of the references cited, a description of the methods used, and a summary of the results obtained.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 9 0 | |
|--|--|--|---|--|---|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | | 2b HOUR | |
| FIRST MIDDLE LAST HARRY G. MC CLELLAN | | | | | MONTH DAY YEAR 05 14 80 | | | | | 7:20 P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | |
| Male | | Caucasian | | MONTH DAY YEAR 1 3 03 | | | 77 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Penna. | | USA | | | | | Prince Georges MD. | | | | |
| 10 CITY OR TOWN OF DEATH | | 11: NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Clinton | | Southern Maryland Hospital | | | | | Retired | | Administration | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a INSIDE CITY LIMITS? | | 13b STREET ADDRESS | | | | |
| 13a STATE 13b COUNTY 13c CITY OR TOWN Florida Dade Miami | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13151 S.W. 17th. Terrace | | | | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST Thomas McClellan | | | | | FIRST MIDDLE LAST Etta Space | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | |
| yes | | | | | unk. | | Md. F.E. McClellan 7816 Lusby's Turn Brandwine | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) PROB CARDIAC RUPTURE & ARREST | | | | | | | | | | | |
| 410- DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) ACUTE ANTERIOSEPTAL MI | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) RECURRENT MI | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 12. cerebral vascular accident + aphasia | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-12 19 80 to 5-14 19 80, that (I) (we) last saw the deceased alive on 5-14 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | | DEGREE | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c DATE SIGNED 5-15-80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e ADDRESS | | | | | | |
| | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | | 5/16/80 | | Metropolitan Crematory | | | Alexandria Va. | | | |
| 24 FUNERAL DIRECTOR NAME | | | | | ADDRESS | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | | | | | | | | |

Item 230 g544 6/13/80 gj

FOR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13591

1- STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST
Rosa Bell McGee

2a. DATE KNOWN OF DEATH ESTI-MATED ☒ 4-21 1980 2b. HOUR M

3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 1-2-90 90 YRS 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS 7c. DATE PRONOUNCED DEAD 4-21 1980 2d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD

10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Housewife 12b. KIND OF BUSINESS OR INDUSTRY Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE N. Carolina 13b. COUNTY Halifax 13c. CITY OR TOWN Scot. Neck 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS Rt. 1 Box 263

14. FATHER'S NAME FIRST MIDDLE LAST William Powell 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joanna White

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 245-56-9904 17. INFORMANT ADDRESS William McGee 303 Serena St. Balt. MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis, the Arteriovascular disease
42922 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) } DUE TO, OR AS A CONSEQUENCE OF
(c) }

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 4-21-80

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 4-26-80 23c. NAME OF CEMETERY OR CREMATORY Mary's Chapel Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Scotland Neck N.C.

24. FUNERAL DIRECTOR NAME ADDRESS Scotland Neck F.H. 202 E. 10th St. S.N., NC 25a. DATE REC'D. BY REGISTRAR APR 29 1980 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 0 | 1 | 3 | 5 | 9 | 2 |
|--|--|--|--|--|--|--|--|--|--|--|---|---|--|-------------------------------|---|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) DOROTHY J. MC GINNIS | | | | | | | | | | 2a DATE OF DEATH MONTH DAY YEAR 05 20 80 | | | | 2b HOUR 5:42 AM | | |
| 3 SEX Female | | | 4 RACE Caucasian | | | 5 DATE OF BIRTH MONTH DAY YEAR May 11 1928 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY, MD. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. HOSP. & MED. CTR. | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse | | | 12b KIND OF BUSINESS OR INDUSTRY Hospital | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) U.S. STATE Maryland | | | 13b COUNTY P.G. | | | 13c CITY OR TOWN Landover Hills | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 7433 Parkwood Str. | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST J. Taylor Crump | | | | | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie M. Durst | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | | | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | | 17 INFORMANT ADDRESS William McGinnis Same as #13e | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC OVARIAN ADENOCARCINOMA</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 YRS</u> | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>SMALL INTESTINAL OBSTRUCTION DUE TO ABDOMINAL CARCINOMATOSIS</u> | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from <u>APRIL 19 79</u> to <u>MAY 19 80</u> , that (I) (we) lost the deceased alive on <u>MAY 19 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b DATE SIGNED <u>5/20/80</u> | | | | | | |
| 22c SIGNATURE <u>James G. Browner</u> | | | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. BROWNE MD</u> | | | | | | | | | | 22e ADDRESS <u>6125 BELCEST RD HYATTSVILLE, MD 20782</u> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 22 May 1980 | | | 23c NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Park | | | 23d LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md. | | | | | | | |
| 24 FUNERAL DIRECTOR NAME Beall F.H. 9013 Annapolis Rd. Lanham, Maryland | | | | | | | | | | 25a DATE REC'D. BY REGISTRAR MAY 26 1980 | | | 25b REGISTRAR'S SIGNATURE <u>John H. McCreedy</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 5 9 3

REG. NO.

| | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) VINCENT William | | | 2a. DATE OF DEATH MONTH May DAY 3 YEAR 1980 | | | 2b. HOUR 6:00 M AM | | | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 1916 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 64 YRS | | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 | | 8. UNDER 24 HRS HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH DC | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH PR Geo | | |
| 10. CITY OR TOWN OF DEATH COLLEGE PARK | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4805 - BERWYN Rd | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk (Law) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Pr. Geo. | | | 13c. CITY OR TOWN College Park | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME FIRST ROSS MIDDLE M LAST MULLEN | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST COWHIG | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO 577-46-1270 | | |
| 17. INFORMANT Margaret C. McMullen (Wife) | | | 18. ADDRESS Same as above | | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ac Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebral DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myocardial Disease | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 2 1980 to May 3 1980 , that (I) (we) lost saw the deceased alive on May 2 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. C. Etienne | | | 22c. DEGREE MD | | | 22d. DATE SIGNED 5-3-80 | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) W. C. ETIENNE | | | 22f. ADDRESS COLLEGE PARK MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-7-1980 | | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md. | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. | | | 24b. ADDRESS Mt. Rainier, Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

7-7-1980
F. J. B. Inc.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 20. DATE OF DEATH | | MONTH | | DAY | | YEAR | |
| Blanche Elizabeth Meade | | | | 5-13-80 | | 7:50 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | Black | | 12-26-1889 | | 90 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| Brandywine | | Residence 16600 Naylor Rd. | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md | | | | P.G. | | Brandywine | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16600 Naylor-Perry Rd. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| George A Walls | | | | Mary Jane Jackson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | 578-12-3128 | | Alfred Johnson 15501 Baden West | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs Years Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 4/10/80 | | | | CARCINOMA Colon | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on May 19 80, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | 4/27, 19 64, to May 13, 19 80 | | | | | | | |
| 22b. SIGNATURE Thomas L. Fieldson M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 13 May 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Thomas L. Fieldson | | | | Brandywine Waddorf Clinic-Brandywine | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| Burial | | | | 5-17-80 | | Myers Ch. Cem. | | Nottingham P.G. | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Martell Adams | | | | Aquasco, Maryland 20608 | | | | MAY 19 1980 | | Fitzroy McCreedy | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 5 9 5 | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) HARRY A. MEYER MYERS | | | | 2a DATE OF DEATH MONTH DAY YEAR 05-05-80 | | | | 2b HOUR 3:43PM | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 21 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD. | | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- C.P.A.-Self-Employed | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a STATE Md. | | | | 13b COUNTY Pr.Geo. | | 13c CITY OR TOWN Hyattsville | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 2410-Lewisdale Drive | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Paul Meyer | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Fredrick | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) - | | 17 INFORMANT ADDRESS 124-10-5779-A Mary E. Meyer (above address) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm of the Aorta</u> 4415 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>March 19 80</u> to <u>5-5 80</u> , that (I) (we) lost saw the deceased alive on <u>5-5 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <u>R. S. Fleischer</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED 5-6-80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) R. S. FLEISCHER | | | | 22e ADDRESS 7411 BIGGS Rd. HYATTSVILLE, MD | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE 5/8/1980 | | 23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Wash., D.C. | | | |
| 24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc. | | | | ADDRESS Mt. Rainier, Md. | | 25a DATE RECD. BY REGISTRAR MAY 13 1980 | | 25b REGISTRAR'S SIGNATURE <u>Barry A. Brady</u> | | | |

3:43PM

05-05-00

HY-5

HARRY

PRINCE GEORGE'S

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

10-10-77-A

Mo

3 5 9 6

REG. NO.

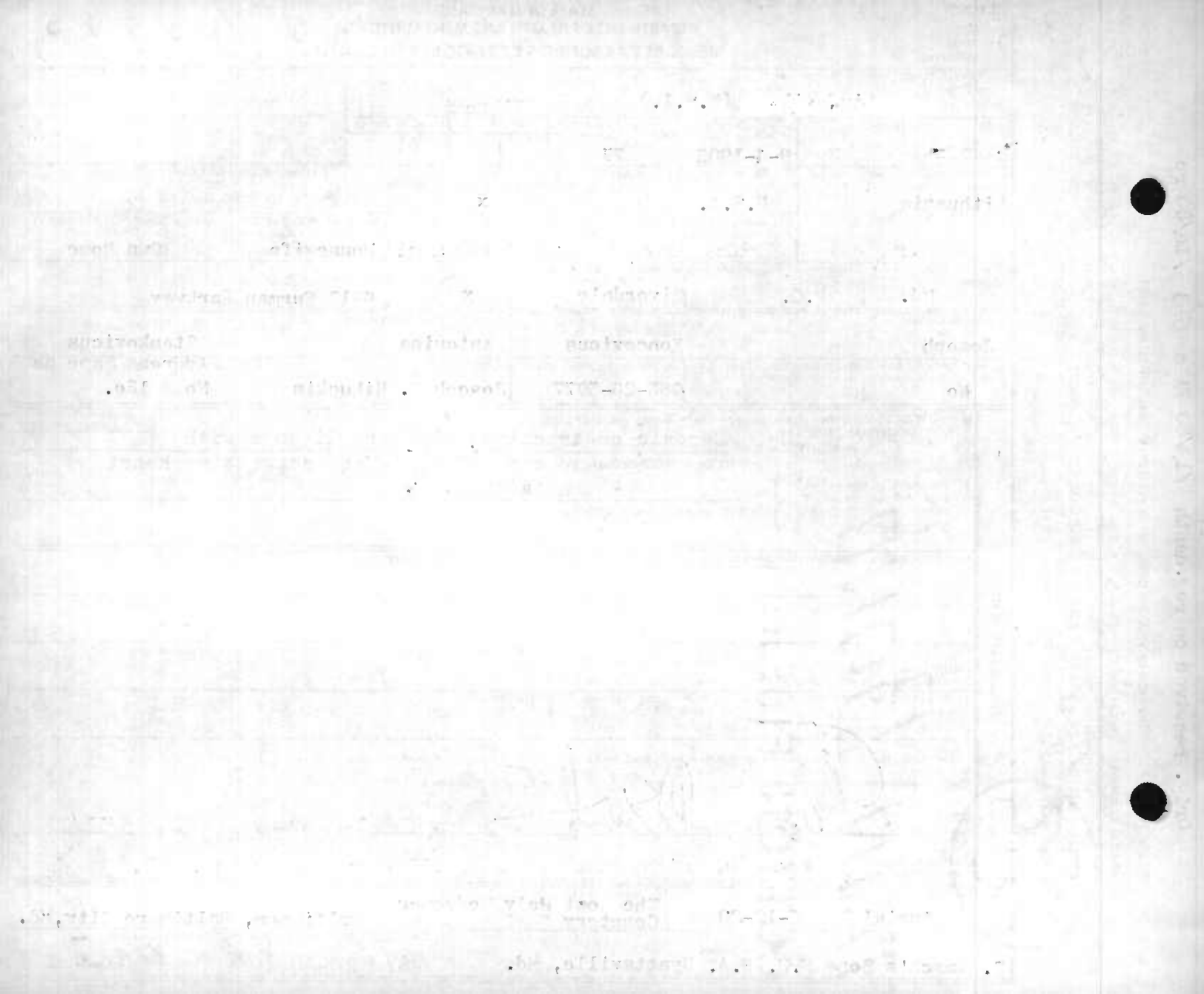
| | | |
|--|---|---|
| 24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Md. | 25a. DATE REC'D. BY REGISTRAR MAY 1 6 1980 | 25b. REGISTRAR'S SIGNATURE <i>P. [Signature]</i> |
|--|---|---|

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

Orig. received on reg. death 5/13/80 Film G543 5/16/80 rc

BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 | 1 3 5 9 7 | | |
|---|--|---|---------------------|--|--|--|--|---|--------------|---|--------------------------------|----------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FORD MORRISON MILAM | | | 2a DATE OF DEATH MONTH DAY YEAR | | | MAY 25, 1980 | | 2b HOUR 10:00A _M | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 30, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VIRGINIA | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILITARY | | 12b KIND OF BUSINESS OR INDUSTRY MILITARY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a STATE VIRGINIA | | 13b COUNTY FAIRFAX | | 13c CITY OR TOWN ALEXANDRIA | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 2059 HUNTINGTON AVE | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN NMI MILAM | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ICY FAITH NMI FITZWATER | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) W.W. II | | 17 INFORMANT ADDRESS MARIACARMEN MILAM SAME AS 13E | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>185-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>WIDESPREAD METASTATIC PROSTATIC CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>RUPTURED GALL BLADDER 3/P CHOLECYSTECTOMY</u> | | | | | | | | | | | | | |
| 19a DATE OF OPERATION FEB 80 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED ABOVE ↑ | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>25 MAY</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Gary S Jewell</u> | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED 25 MAY 80 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) GARY S. JEWELL | | | | 22e ADDRESS MG USAF MC AAFB, MD 20331 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b DATE 5-29-80 | | 23c NAME OF CEMETERY OR CREMATORY Arl. National Cemetery | | | | 23d LOCATION CITY OR TOWN COUNTY STATE Arl., Va. | | | | | |
| 24 FUNERAL DIRECTOR NAME Evenly-Wheatley | | | | ADDRESS ALEXANDRIA, VA | | | | 25a DATE RECEIVED BY REGISTRAR JUN 3 1980 | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

Every-Wholly Alexander, Jr.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

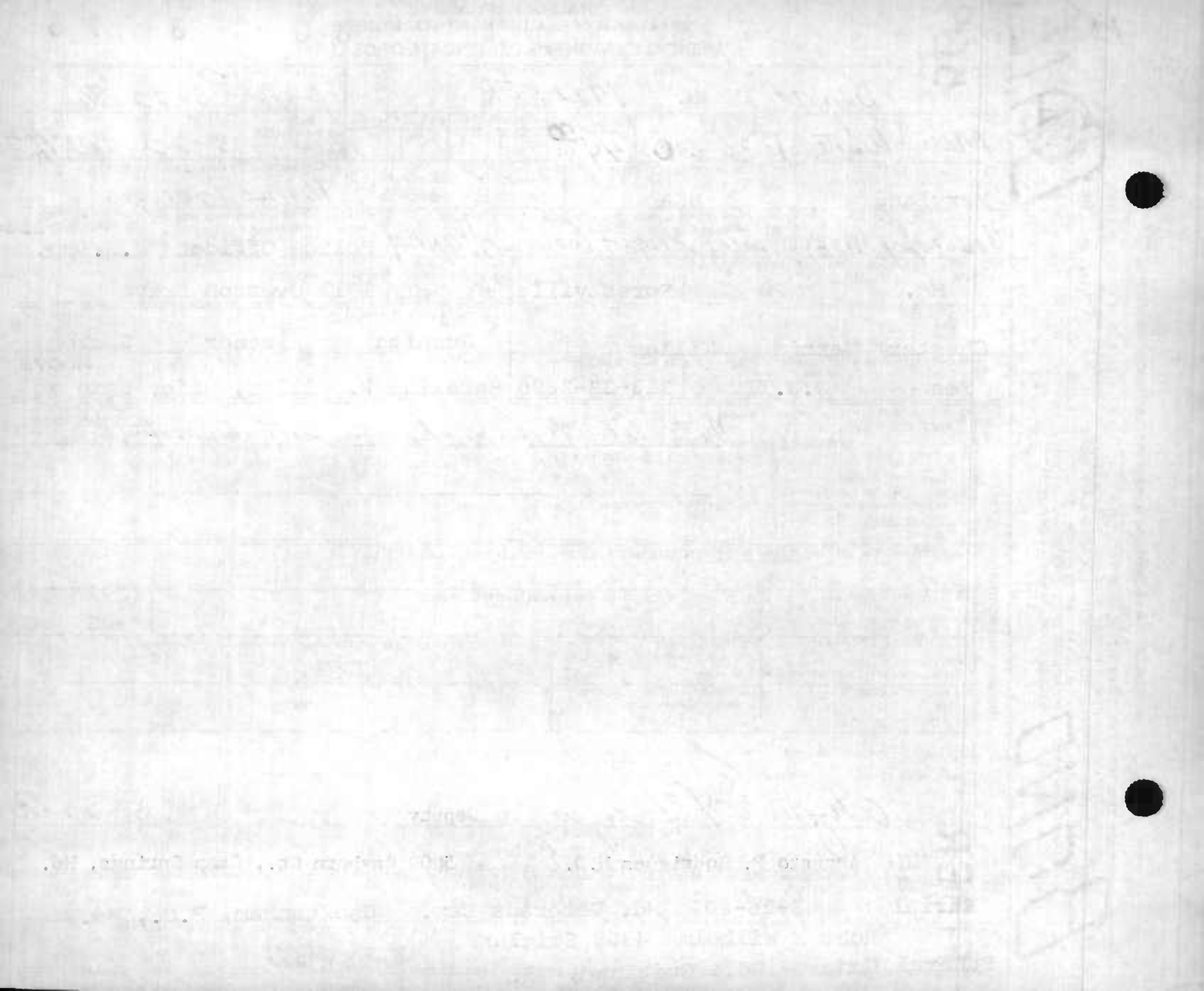
DHMH - 17
(VR A15 ME (5))
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|---------|---|--------|--|-------------------------|---|---------------------|--|----------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Donald S. MILLER | | | | | 5-22-80 | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED | | 2d. HOUR | | |
| Male | White | 1-26-30 | | 50 YRS. | | | 5-22-80 | | 9:22 A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly (DOA) | | Prince Georges General Hospital | | | | Police Officer | | U.S. Cap. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | PG | | Forestville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1911 Overton Drive | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Chester Martin Miller | | | | Juanita Eleanor Sharon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Yes | | | | W.W.II | | 213-22-2890 | | Madeline R. Miller, Wife, Same as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Methicillin hypersensitivity with hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | MEDICAL EXAMINER | | DATE SIGNED | | | |
| Augusto P. Rodriguez | | Deputy | | | | | | 5-22-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Augusto P. Rodriguez M.D. | | 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 5-26-80 | | Md. Veterans Cem. | | Cheltenham, P.G., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robt E Wilhelm 4308 Suitland | | MAY 28 1980 | | | | [Signature] | | | | | |
| Funeral Home | | Rd., Suitland, Md. | | | | | | | | | |



Item #8 Film G554 4/3/81

FOR
1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13599

| | | | | | | | | |
|---|-------------------------|--|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>William Eugene MILLER</i> | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-11 1980 | | | 2b. HOUR M | | |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>11-5-54</i> | 6. AGE (IN YEARS) LAST BIRTHDAY <i>25</i> YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED <i>5-11</i> 1980 | 2d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Painter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i> |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>P.G.</i> | | 13c. CITY OR TOWN <i>Clinton</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>George W. Miller</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie June Pates</i> | | 16. SOCIAL SECURITY NO. <i>215-62-2771</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>215-62-2771</i> | | 17. INFORMANT ADDRESS <i>George W. Miller (Father) Same as #13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rifle wound of the chest</i> 9552 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2:45 P.M. 5-11 1980</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Self-inflicted</i> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>7724 Woodyard Road, Clinton, Prince Georges</i> | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER | | | DATE SIGNED <i>5-11-80</i> | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs Md. 20031</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>5/14/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P.G. Co.</i> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Lee Funeral Home Inc.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 20 1980</i> | | | 25b. REGISTRAR'S SIGNATURE <i>History Delaney</i> | | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR: [Illegible]

FOR THE SAC: [Illegible]

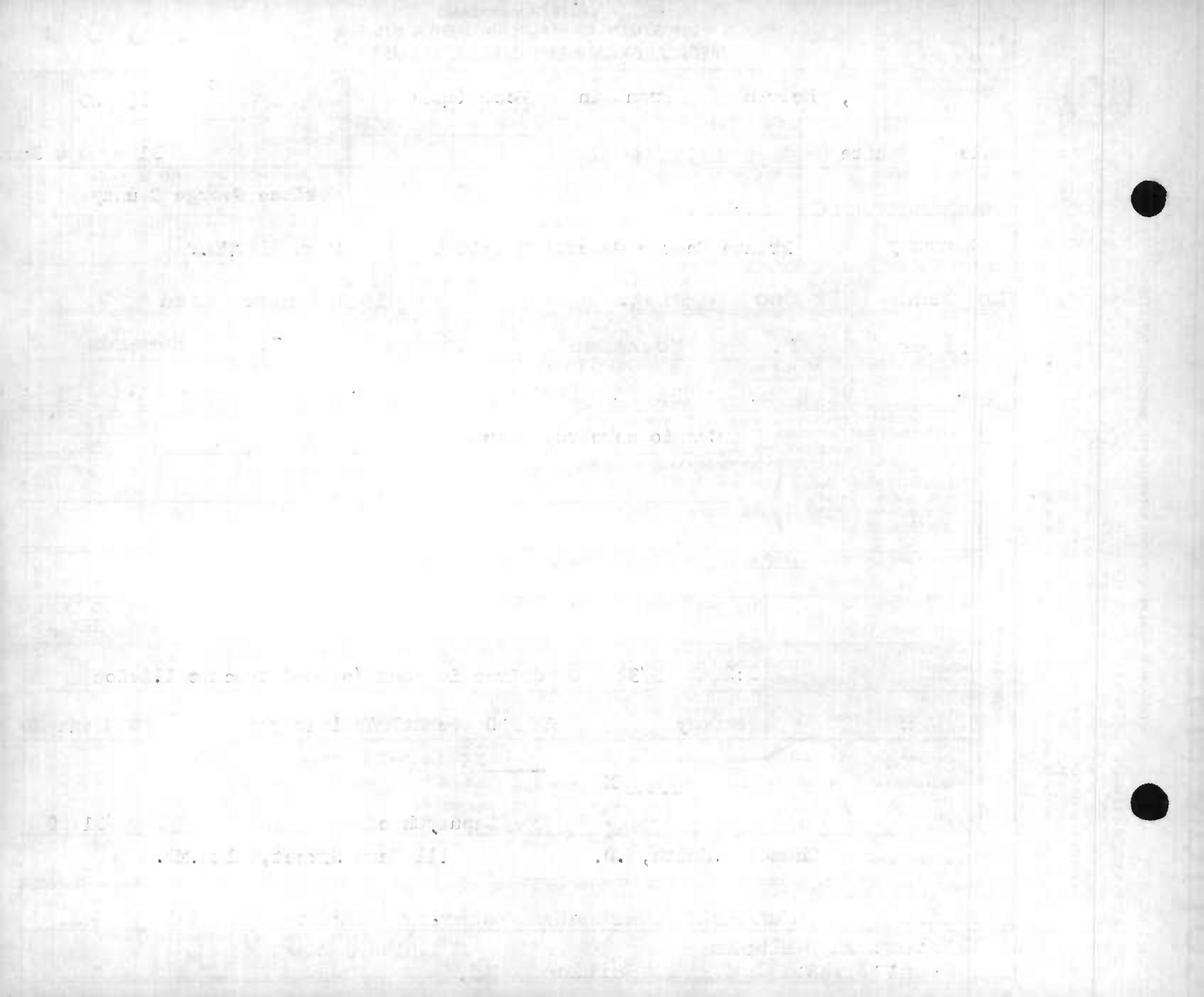
FOR THE ASAC: [Illegible]

FOR THE CLERK: [Illegible]

FOR THE [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13600 | |
|---|--|---|--|---|--|---|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. DATE OF DEATH | |
| | | Melvin Franklin Mockabee | | | | | | xx MONTH 5 DAY 31 YEAR 1980 | | 2b. HOUR 4:38 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| male | | white | | Sept 12, 1949 | | 30 YRS. | | MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | |
| Washington DC | | U.S.A. | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | Prince George General Hospital | | | | Firefighter | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Pr Geo | | Dist. Hgts, | | YES NO | | 1920 County Road | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Elmer F. Mockabee | | | | Louise C. Edwards | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| Yes | | | | Viet Nam | | 218 58 1471 | | | Frances Hayes Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio cerebral trauma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 7 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES xx NO | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 3:20AM 5/31/80 | | | | driver in auto/parked truck collision | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | |
| roadway | | | | Rt #50 over Rt 704 Palmer Hwy | | | | PG County MD | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident <input checked="" type="checkbox"/> Suicide Homicide Undetermined manner | | | | | | | | | | | |
| 22b. Autopsy Inspection Inquiry and in my opinion | | | | | | | | | | | |
| 22c. Actual Signature | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Thomas D. Smith, M.D. | | | | Deputy Chief | | | | 5/31/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| 111 Penn Street, Balto. MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN) | | COUNTY STATE | |
| Burial | | | | 4 June 1980 | | Cheltenham Veterans | | Cheltenham | | PG Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm | | | | | | JUN 10 1980 | | | | | |
| Funeral Home Ind | | | | | | Suitland, Md. | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13601 | | | |
|---|--|------------------|--|--|--|---|--|--|-----------------------|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA M. MOORE | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 1 1980 | | 2b. HOUR M 2:50 P M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 14 1951 | | 6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. | | | | 7b. CITIZEN OF WHAT COUNTRY? C. U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary. H. E. W. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland. | | | | 13b. CITY OR TOWN Prince Geo. | | 13c. CITY OR TOWN Takoma Park. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 714 Auburn Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John E. Moore. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret B. Burke. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No. | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-58-5916 | | 17. INFORMANT ADDRESS Margaret B. Moore. 13 e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anorexia nervosa</u> 3071 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i> | | | | | | TITLE (SPECIFY) M.D. Assistant | | | DATE SIGNED 5/2/80 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial. | | | | 23b. DATE May 5, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR NAME J. Arthur Walters. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Jeffrey McNeely</i> | | | | | |

1947

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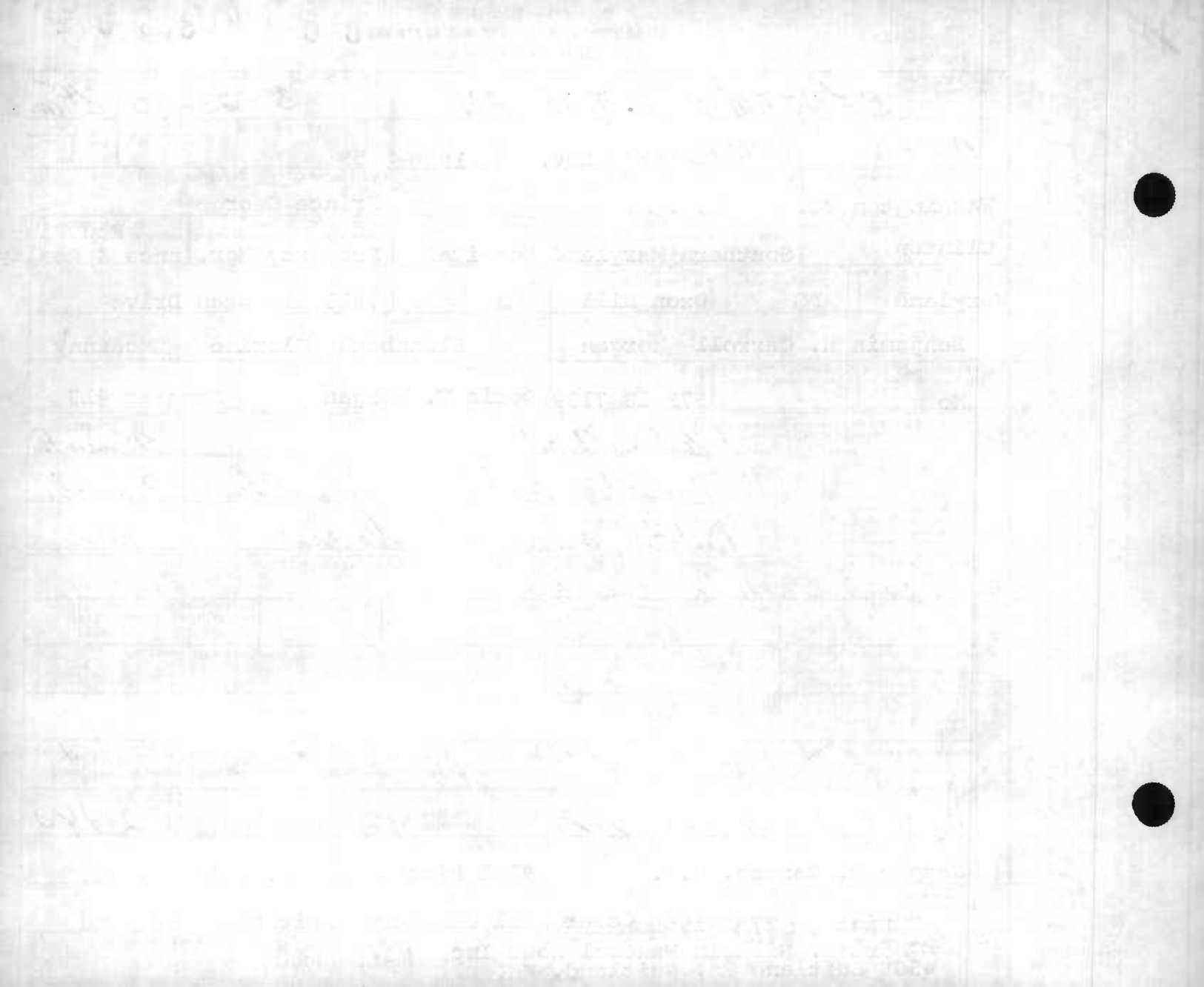
1947

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) BENJAMIN H. MORGAN | | | 2a DATE OF DEATH MONTH DAY YEAR 5-23-80 | | | 2b HOUR 8:45 PM | | | |
| 3 SEX MALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 28 1920 | | 6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | 7b CITIZEN OF WHAT COUNTRY? U.S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Property Mgr. | | 12b KIND OF BUSINESS OR INDUSTRY Finance & Realty | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE Maryland | | 13b COUNTY PG | | 13c CITY OR TOWN Oxon Hill | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Benjamin H. Carroll Morgan | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Florine McKinny | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 18 7139 | | 17 INFORMANT Doris V. Morgan | | | | ADDRESS Same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Aneurysm 2507 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral heart failure + Pulmonary Edema (c) Death Cerebral Aneurysm disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes 3 months 7 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Vascular Disease | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5/23 19 80 , to 5/23 19 80 , that (I) (we) last saw the deceased alive on 5/23 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Joseph P. Caruso M.D. | | | | DEGREE | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c DATE SIGNED 5/23/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph P. Caruso, M.D. | | | | 22e ADDRESS 9131 Piscataway Rd. Clinton, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 27 May 1980 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md | | | |
| 24 FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home Inc 4308 Suitland Rd., Suitland, Md. | | | | 25a DATE REC'D. BY REGISTRAR MAY 28 1980 | | 25b REGISTRAR'S SIGNATURE Notary Public | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|---|---|---|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | 7013603 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| Helen Florence Morrison | | | | | 05 06 80 6:10A M | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | Caucasian | | 03 29 92 | | 88 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington DC | | USA | | | | Prince Georges MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clinton | | Southern Maryland Hospital | | | | Housewife | | --- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | 13e. STREET ADDRESS | | | | |
| Md. Pr. George Hyattsville | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> 6622 Stockton Lane | | | | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST William MIDDLE Hayes LAST | | | | | FIRST Florence MIDDLE Beall LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | |
| No | | | | | 579 07 7847 | | Everett F. Morrison Same as #13 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsisemia.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>pneumonia.</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Congestive heart failure, Renal failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| --- | | | --- | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>5.6.1980</u> to <u>5.6.1980</u> , that (we) last saw the deceased alive on <u>5.5.1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Nemat, M.D.</u> | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 5.6.80. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| NEMAT, Massoud Nemat | | | | | | 1600 S. Joyce Dr., Arlington, Va. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 8May1980 | | Cedar Hill Cem. | | Suitland PG Maryland | | |
| 24 FUNERAL DIRECTOR NAME | | | | | | 25a. DATE BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E. Wilhelm | | | | | | MAY 9 1980 | | <u>Robert E. Wilhelm</u> | |
| Funeral Home Inc | | | | | | Suitland Md. | | | |

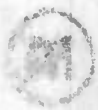
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. 70 13604 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Andrew H. Murphy | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 3, 1980 | | 2b. HOUR 6:00P M | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 08 16 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ieland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Labor Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Brentwood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3424 - Tilden Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John A. Murphy | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eula Clodfelter | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS Same as above | | | 17. INFORMANT ADDRESS Same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic + congestive heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4149</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> , 19 <u>80</u> to <u>5/3</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John R. Melnick MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>5/4/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-7-80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Henry McCready</u> | | | |



No. Carolina

University

Mr. J. H. ...

John ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 0 5


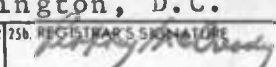
REG. NO.

| | | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) John R. Neuman Jr. | | | 2a DATE OF DEATH MONTH DAY YEAR 5 1 80 | | | 2b HOUR 7 P M | | | | |
| 3 SEX Male | | 4 RACE 1 Negro | | 5 DATE OF BIRTH MONTH DAY YEAR 9-9-51 | | 6 AGE (IN YEARS LAST BIRTHDAY) 28 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. U.S.A. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County, MD | | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b KIND OF BUSINESS OR INDUSTRY Laborer | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | 13b COUNTY Prince George | | 13c CITY OR TOWN Upper Marlboro | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John A. Neuman Sr. | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Swann | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. 217-60-8001 | |
| 17 INFORMANT John A. Neuman | | | 18 ADDRESS 9900 Roseryville Rd. Upper Marlboro, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 2826 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sickle Cell Disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-1-80 to 5-1-80, that (I) (we) last saw the deceased alive on 5/1/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE Stephen Goldberger MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 3 May 80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Goldberger MD | | | 22e ADDRESS 7801 Old Branch Ave. Clinton, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE May 5, 1980 | | 23c NAME OF CEMETERY OR CREMATORY Holy Rosary Church | | 23d LOCATION CITY OR TOWN COUNTY STATE Up. Marlboro PR, G. Md. | | | |
| 24 FUNERAL DIRECTOR NAME 6633 Old Alexander Ferry Rd. Clinton, Md | | | 25a DATE REC'D. BY REGISTERAR 1580 | | | 25b REGISTERAR'S SIGNATURE | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 6 0 6 | |
|--|--|---|--|--|--|---|--|--|--|---------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) Byrd D. Newton | | | | | 2a DATE OF DEATH MONTH DAY YEAR May 7, 1980 | | | 2b HOUR 3:25 PM | | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County, MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Adelphi | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | 13b COUNTY Montgomery | | 13c CITY OR TOWN Potomac | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 9417 Duxford Court | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Leonard Presson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah (Unknown) | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO 415 28 5332 | | 17 INFORMANT James M. Deck Same as 13c, Md. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal cerebral thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | 1977 to 5/7/80 | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from April 1980 to 5/7/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE  | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 5/7/80 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Osoth Lekagul, M.D. | | | | | 22e ADDRESS 4200 Everett St. Kensington, Md. | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE May 9, 1980 | | 23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | |
| 24 FUNERAL DIRECTOR NAME ROBERT A. PUMBUREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND | | | | | 25a DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b REGISTRAR'S SIGNATURE  | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|--|---|--|---------------|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William L. Norton</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>May 17 1980</i> | | | 2b. HOUR <i>9:35 PM</i> | | | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>10-3-1901</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Alabama</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Pr. Geo.</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH <i>Greenbelt</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greenbelt Convalescent Center</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. U. S. Special Police</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Pr. Geo.</i> | | 13c. CITY OR TOWN <i>Bladensburg</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>4203 - 58th Avenue</i> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>James W. Norton</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha C. Groover</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>-</i> | | 17 INFORMANT ADDRESS <i>Frances E. Norton (Wife)</i> | | | Same as above | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Occlusion</i> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 weeks</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>19 May 1980</i> to <i>17 May 1980</i> , that (1) (we) last saw the deceased alive on <i>19 May 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Wm. D. W. Smith MD</i> | | | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>17 May 1980</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5-20-80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md.</i> | | | | | |
| 24 FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc. Mt. Rainier, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 6 0 8
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VIOLET B. O'GRADY | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 29 80 | | | 2b. HOUR 6:05 P.M. | | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR April 20, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NYC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Va. | | | 13b. COUNTY Roanoke | | 13c. CITY OR TOWN Roanoke | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 142 Lee Ave. N. E. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Knauer Clara Schofield | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. IF YES, GIVE WAR OR DATES ----- 213-88-5432 | | 17. INFORMANT ADDRESS Claribel R. Bouvier same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>terminal cerebral infarction</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1980 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1977, 19 to 1980, 19, that (I) (we) lost saw the deceased alive on 5/28/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE  DEGREE MD | | | | | | 22c. DATE SIGNED 5/29/80 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSO TH LEXAGUL MD | | | | | | 22e. ADDRESS 7425 Arlington Rd Bethesda Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6-2-80 | | 23c. NAME OF CEMETERY OR CREMATORY N, Hardyston Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hardyston N.J. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Home 12 Ridgely Ave. Ann. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | | 25b. REGISTRAR'S SIGNATURE  | | |

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11

JUN 1 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 0 1 3 6 0 9 | |
|---|--|---|--|--|--|---|---|---|--|---------------|--|
| FOR 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) James O'MALLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 22, 1980 | | | 2b. HOUR 1:20 A M | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 10-12-32 | | 6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown | | 7b CITIZEN OF WHAT COUNTRY? Unknown | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD | | | | | |
| 10 CITY OR TOWN OF DEATH Glenn Dale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown | | 12b KIND OF BUSINESS OR INDUSTRY Unknown | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE NO 13b COUNTY UNK 13c CITY OR TOWN UNK | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS No fixed address | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-54-3885 | | 17 INFORMANT Decedent | | | ADDRESS Unknown | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebrovascular accident w/hemiplegia and basal cell carcinoma | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 19, 1979 to May 22, 1980 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 22, 1980 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE James W. Wills, M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED May 22, 1980 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D. | | | | | 22e ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769 | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b DATE 6-10-80 | | 23c NAME OF CEMETERY OR CREMATORY ANATOMICAL BOARD | | 23d LOCATION CITY OR TOWN COUNTY STATE Howard Univ. Hosp. Wash. D.C. | | | | | |
| 24 FUNERAL DIRECTOR NAME 19th Street & Massachusetts Avenue, S.E. | | | | 25a DATE REC'D. BY REGISTRAR JUN 13 1980 | | 25b REGISTRAR'S SIGNATURE Roger M. D. | | | | | |

PAGE 1520114

Figure 1. The effect of the concentration of the inhibitor on the rate of polymerization of α -methylstyrene in the presence of SnCl_4 at 50°C .

1901 2 11 11

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DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13610 | |
|---|--|-----------------------------|--|--|--|---|--|--|--|--|--|---|--|---|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM J. CACHEO | | | | | | | | | | 20. DATE KNOWN DEATH ESTI- MATED <input checked="" type="checkbox"/> 5-8-1980 | | 21. DATE PRONOUNCED DEAD 05 08 80 | | 22. HOUR 10:15 | | | | | | | |
| 3. SEX MALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 02 24 47 | | 6. AGE (IN YEARS) LAST BIRTHDAY 33 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 23. DATE PRONOUNCED DEAD 05 08 80 | | 24. HOUR 10:15 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | | | 12b. KIND OF BUSINESS OR INDUSTRY Residential | | | | | | | | | |
| 13a. STATE Florida | | | | 13b. COUNTY Palm Beach | | | | 13c. CITY OR TOWN Lake Worth | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 6990 State Rd 7 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Austin L. Pacheco Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Tacy | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 216-50-8920 | | | | 17. INFORMANT Chris Mar Drive | | | | 18. ADDRESS 6101 Chris Mar Drive Austin L. Pacheco Clinton, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of the head 9554 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 603 P.M. 5-8 1980 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-8 1980 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6101 Chris Mar Drive, Brandysburg, Pa. 15005 | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | DATE SIGNED 5-9-80 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE May 10, 1980 | | | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat'l. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | | ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1980 | | | | 25b. REGISTRAR'S SIGNATURE Dorothy McCreedy | | | | | | | | | |



RECEIVED BY 24 47 2003

France Telecom

Construction and Electrical Contractor

2000 State St

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

San Francisco

2000 State St

San Francisco

San Francisco

San Francisco

San Francisco

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13611 | |
|---|---------------------------------|--|---|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Russell E. PACKETT Jr.</i> | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>5-2 1980</i> | | 2c. DATE PRONOUNCED DEAD <i>5-2 1980</i> | | 2d. HOUR | |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>2-10-16 64</i> | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>64</i> | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD <i>5-2 1980</i> | | 7d. HOUR | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> | | | MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Hyattsville</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1413 Ray Road</i> | | | | 12a. <i>Foreman</i> (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Meatcutter Ret.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>US Gov't</i> | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>1413 Ray Road</i> | | | |
| 13a. STATE <i>Maryland</i> | 13b. COUNTY <i>Pr. Geo's</i> | 13c. CITY OR TOWN <i>Hyattsville</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Delano</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Emory Packett</i> | | | 16. SOCIAL SECURITY NO. <i>579-10-9143</i> | | | 17. INFORMANT ADDRESS <i>Russell E. Packett Jr. New Carrollton Maryland</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>579-10-9143</i> | | | 17. INFORMANT ADDRESS <i>Russell E. Packett Jr. New Carrollton Maryland</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant hypernephroma</i> <i>1890</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | TITLE (SPECIFY) <i>Deputy</i> | | | MEDICAL EXAMINER | | | DATE SIGNED <i>5-3-80</i> | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (a) <i>Burial</i> | | | 23b. DATE <i>5/4/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Warsaw Bapt. Ch Cem</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Warsaw Richmond Va.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Francis Gasch's Sons, PA Hyattsville, Md.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 6 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i> | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Lewis Edwin Parker Sr</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5-25-80</i> | | | 2b. HOUR P. M. <i>3:00</i> | | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11-28-12</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>67</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Clinton</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Md. Hospital Cntr</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Plumber</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Private Industry</i> | | |
| 13a. STATE <i>Md</i> | | | 13b. COUNTY <i>Pr. Geo's</i> | | 13c. CITY OR TOWN <i>Brandywine</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>Box 65</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>James Irving Parker</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillian J. Garner</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unk.</i> | | | 16b. SOCIAL SECURITY NO. <i>216-10-8961</i> | | 17. INFORMANT ADDRESS <i>Box 65</i> <i>Esta Mae Parker-Brandywine, Md 20613</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of testis</i> 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Prostate</i> DOE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-22-80</i> to <i>5-25-80</i> , that (I) (we) lost saw the deceased alive on <i>5-24-80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard H. Dobson</i> | | | DEGREE <i>MD</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-25-80</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard H. Dobson, M.D.</i> | | | 22e. ADDRESS <i>Brandywine, Maryland</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i> | | | 23b. DATE <i>5/29/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Clinton (Pr. Geo's) Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Richard A. Coleman - Upper Marlboro, Maryland 20870</i> | | | | | | 25a. DATE REC'D BY REGISTRAR <i>JUN 13 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

7
James George
Southern Railway
Box 62
Birmingham
Alabama
210-10-1001

10/10/60
Southern Railway
Birmingham
Alabama

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13613

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|--|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Ethel Virginia | | PAYNE | | | | | | 5-4 | | 19 | | 80 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED | | MONTH | | DAY | | YEAR | |
| Female | White | 9-19-19 | | 66 YRS. | | | | | | 5-4 | | 19 | | 80 | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD | |
| Virginia | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Cheney | | Prince George General Hospital | | Housewife | | Own Home | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | |
| Md. | | P.G. | | Edmonston | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5102 Crittenden Street | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | |
| Morris | | Maurice | | Ryan | | Ida | | Lee | | Haley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | Address Same as | | | | | | | | | |
| No | | 215-62-5283 | | Beverly J. Jackson | | No# 13e. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 4292 | | Arteriosclerotic Cardiovascular disease | | | | | | | | | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | | | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | DATE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | 5-4-80 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Augusto P. Rodriguez | | 5009 Rayburn Court, Camp Springs | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | STATE | | | | | | | | | |
| Burial | | 5-8-80 | | Warrenton Cemetery | | Warrenton, Fauquier, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| F. Gasch's Sons | | F.H. P.A. Hyatts. Md. | | MAY 7 1980 | | Rickey McCreedy | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Virginia" and "1911" are faintly visible.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

1 3 6 1 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Louise SHACKELFORD Pearson | | 2a DATE OF DEATH MONTH DAY YEAR May 18, 1980 | | 2b HOUR 1:30P M | |
| 3 SEX FEMALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR JUNE 12, 1913 | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 66 YRS MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD. | |
| 10 CITY OR TOWN OF DEATH Laurel | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. MGR. CAFETERIA | | 12b KIND OF BUSINESS OR INDUSTRY MONT SCHOOL |
| 13a STATE MARYLAND | | 13b COUNTY MONTGOMERY | | 13c CITY OR TOWN SILVER SPRING | |
| 14 FATHER'S NAME FIRST MIDDLE LAST CLARENCE SHACKELFORD | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL KNIGHT | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 215-36-4873 | | 17 INFORMANT HAROLD G. PEARSON | |
| | | | | ADDRESS SAME AS 13 HUSBAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) GB bleed (c) anemia DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) renal failure, pulmonary failure | | | | | |
| 19a DATE OF OPERATION 4/20/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GB bleed | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-9 , 19 80 , to 5-18 , 19 80 , that (I) (we) lost saw the deceased alive on 5-17 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Michael A. Pearson MD | | DEGREE MD | | 22c. DATE SIGNED 5/18/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Pearson | | 22e. ADDRESS 1109 Spring St Silver Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 5/19/80 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | |
| 24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1980 | | 25b. REGISTRAR'S SIGNATURE Robert H. Brady | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

506 UNIT, BLVD. M., SILVER SPRING, MD. 20901
FRANCIS J. COLLINS
CREATION

5/19/80 METROPOLITAN CREATION, ALEXANDRIA VIRGINIA

NO. 215-86-4875 HAROLD G. PETERSON SAME AS 13 MISSING

CLARENCE SHACKELFORD HANDEL NIGHT

HARMANO MONTGOMERY SILVER SPRING X 1131 UNIT, BLVD. WEST

VIRGINIA WHITE FEMALE
U.S.A. WHITE
JUNE 12, 1913 66

SHACKELFORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 0 | 1 | 3 | 6 | 1 | 5 |
|---|--|--|---|---|--|---|--|--|--|---|---|---|---|-----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances A. Perry | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-9-80 | | | | 2b. HOUR 9:55A | | |
| 3 SEX F | | | 4 RACE W | | | 5. DATE OF BIRTH MONTH DAY YEAR 12 18 94 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Howard | | | 13c. CITY OR TOWN Columbia | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 4959 Woodward Gardens | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. McCreery | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Jones | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | | 16b. SOCIAL SECURITY NO. 074-30-3573 | | 17. INFORMANT ADDRESS Columbia, Md 21044 Francis Perry 4959 Woodward Gardens | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4049 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIO DUE TO, OR AS A CONSEQUENCE OF (c) RENAL VASCULAR DIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): TERMINAL BRONCHIAL PNEUMONIA | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/17 1980 to 5/9 1980 , that (I) (we) last saw the deceased alive on 5/18 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD | | | | | | | | | | DEGREE | | 22c. DATE SIGNED 5/9/80 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick W. Schneider | | | | | | | | | | 22e. ADDRESS 201 8th SE N.E. Washington D.C. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-13-80 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Long Island New York | | | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley F.H. Mt. Rainier, Md 20822 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1980 | | 25b. REGISTRAR'S SIGNATURE Henry McCreedy | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 6 1 6 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM HENRY POOLE II | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 1 1980 | | 2b. HOUR 10:52 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 26, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow A.A.F.B. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Mechanic | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. CITY OR TOWN P.G. Oxon Hill | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Llewellyn S. Poole | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna B. Eppley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS Catherine E. Poole Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>1 MAY</u> 19 <u>80</u> , to <u>1 MAY</u> 19 <u>80</u> , that (we) lost saw the deceased alive on <u>1 MAY</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>E. Rupert</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1 MAY 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD G. RUPERT, CAPT, USAF, MC | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/5/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | | 25. DATE REC'D. BY REGISTRAR MAY 6 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u> | |
| 6633 Old Alexander Ferry Road Clinton Md. | | | | | | | |

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Male
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June 26, 1998
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Prince Georges
Camp Springs
Harvard I.C.
Llewellyn S. Locke
579-07-0402
me
Locke I.C. as 12

Lee Harvey, Inc.
579-07-0402
Cedar Hill Cemetery
May 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|---|--|------------------------------------|--|---|-----------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8013617 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| DEBORAH KAY POWELL | | | | | MAY % 5 1980 | | | | | 9:20 A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. MONTHS | | 8. UNDER 24 HRS | |
| F | | White | | July 8, 1962 | | 17 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N. Carolina | | USA | | Prince George's MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Lanham | | Doctors' Hosp. of Pr. Geo. Co. | | | | student | | high school | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md | | | | | PG | | Laurel | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | 16. STREET ADDRESS | | | |
| Donald Isaac Powell | | | | | Sharon Kay Campbell | | | 104 Bryan Court | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | |
| no | | | | | 219 88 2058 | | Donald I. Powell same as above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 2370 | | | | | | | | | | 40 hours | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Treatment for Pulmonary Emboli</u> | | | | | | | | | | 10 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Post-operative State Following Craniotomy</u> | | | | | | | | | | 20 days | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| Mar 12 1980 | | | Brain Tumor (Ganglioglioma) | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | 21g. CITY OR TOWN | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET | | | COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 5</u> 19 <u>80</u> to <u>May 5</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>May 5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Joel L. Falik | | | | | | M.D. | | | May 6, 1980 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| JOEL L. FALIK, M.D. | | | | | | 6005 LANDOVER RD. CHEVERLY MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | May 8, 1980 | | Ivy Hill Cemetery | | | Laurel, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. MAY 11 1980 | | | 25b. REGISTRAR'S SIGNATURE | | |
| Donaldson Funeral Home, Laurel, Maryland | | | | | | | | | | | |

| | | | | |
|--------------------------------|--------------|--------|-----|-----------|
| 17 | July 8, 1982 | White | USA | Carolinas |
| | | | | |
| Student | | | | |
| High School | | | | |
| 104 Byron Court | X | Latent | PO | NO |
| Sharon Kay Campbell | | | | |
| Donald Isaac Howell | | | | |
| 219 48 2028 | | | | |
| Donald E. Howell same as above | | | | |

Initial May 8, 1980 Ivy Hill Cemetery
 Donaldson Funeral Home, Laurel, Maryland
 Laurel, Maryland

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 6 1 8 | | | |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beverly Jean Price | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 21, 1980 | | 2b. HOUR 8:02 P.M. | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Jan 25, 1934 | | 6 AGE (IN YEARS LAST BIRTHDAY) 46 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Prince Georges | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. CITY OR TOWN Pr. Geo. | | 13c. STREET ADDRESS Riverdale | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Angelo J. Catone | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Licht | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 230 42 0331 | | 17 INFORMANT ADDRESS Andy Price 1428 Grimm Rd. Severn Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hepato renal Failure</u> 2894 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of the liver with partial Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypersplenism and thrombocytopenia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Massive gastrointestinal bleeding.</u> | | | | | | | |
| 19a. DATE OF OPERATION May 9, 1980 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Splenectomy and ligation of Varices | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-7-1980</u> 19____, to <u>5-21-1980</u> 19____, that (I) (we) lost saw the deceased alive on <u>5-31-1980</u> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE CHIN-CHUAN HSU M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 5/21/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHIN-CHUAN HSU | | | | 22e. ADDRESS 1905 Baltimore Boulevard College Park Md 20740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 23 MAY 80 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | |
| 24 FUNERAL DIRECTOR NAME Beall Funeral Home 9013 Annapolis Rd. Lanham, Md. 20801 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1980 | | 25b. REGISTRAR'S SIGNATURE P. J. McCreedy | |

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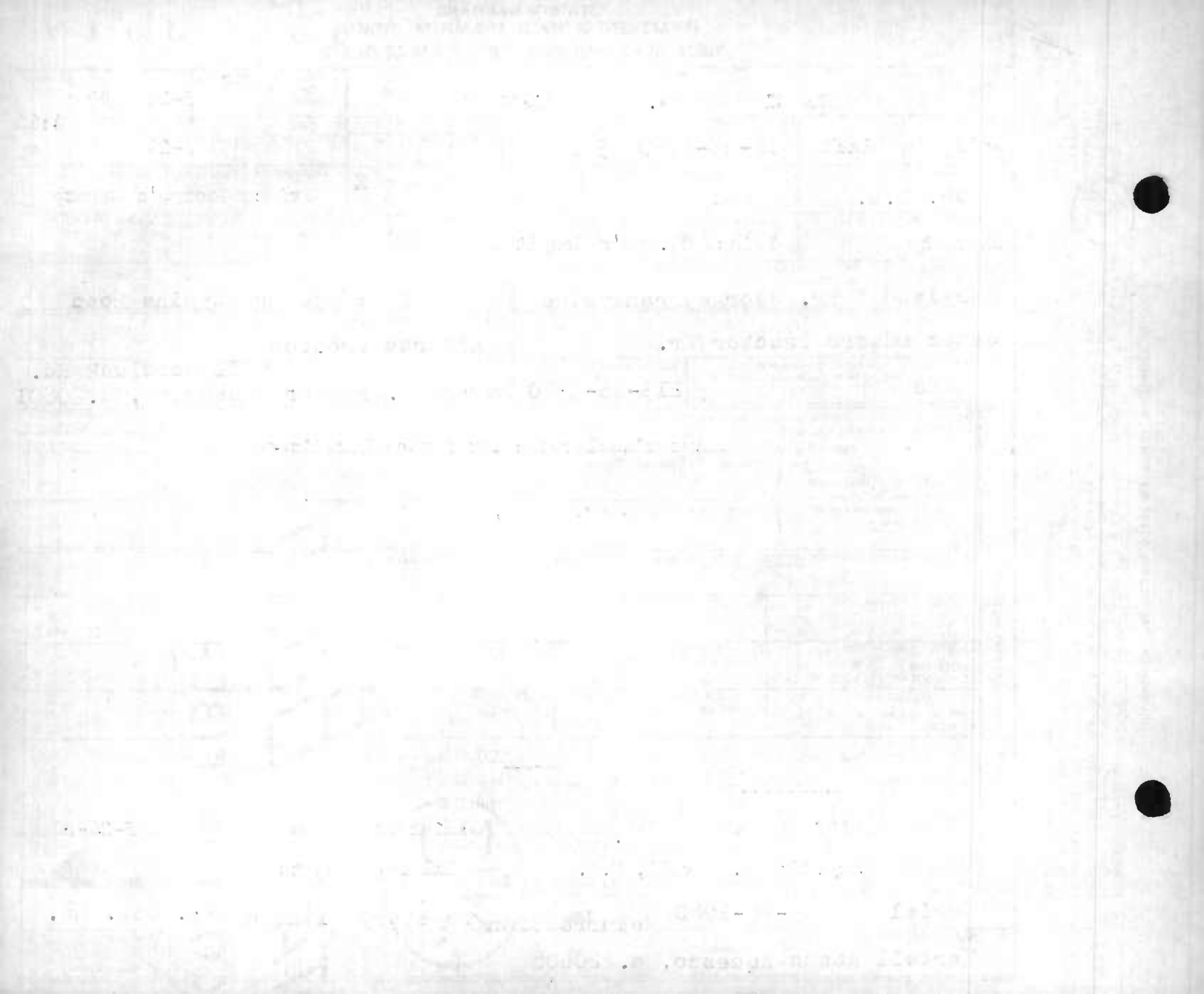
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PIA. 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 0 13619 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS A. PROCTOR | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-24 1980 | | 2b. HOUR 4:40 a.m. | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 12-25-1947 | | 6. AGE (IN YEARS) LAST BIRTHDAY 32 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-24 1980 | | 7. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Pr. George Brandywine | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 15530 Brandywine Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Edward Proctor Jr. | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Proctor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-46-5580 | | | | 17. INFORMANT Edward H. Proctor Seabrook, Md. 20801 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 5-24-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-28-1980 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Martell Adams Aquasol, Md. 20608 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 29 1980 | | 25b. REGISTRAR'S SIGNATURE Patricia Helms | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 6 2 0 | |
|--|---|--|---|--|---|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) George L. Proctor | | | 2a DATE OF DEATH MONTH DAY YEAR May 18, 1980 | | 2b HOUR 8:38p M |
| 3 SEX Male | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR 10-23-1934 | | 6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10 CITY OR TOWN OF DEATH Riverdale | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b KIND OF BUSINESS OR INDUSTRY Labor |
| 13a STATE Md. | | 13b COUNTY P.G. | 13c CITY OR TOWN Md. Park | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George L. Proctor, Sr. | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Washington | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO 220-20-6297 | | 17 INFORMANT ADDRESS Joseph Boone-Same as # 13 above | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Esophageal Carcinoma</u> <u>1509</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (the hospital) attended the deceased from <u>5/18</u> 19 <u>80</u> to <u>5/18</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Byrl D. Johnson</u> | | DEGREE MD. | | 22c DATE SIGNED 5/19/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Byrl D. Johnson, M.D. | | 22e ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20840 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 5-23-80 | 23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Highland Park, Md. | |
| 24 FUNERAL DIRECTOR NAME H.S. WASHINGTON + SONS | | ADDRESS 4925 BURROUGHS AVE. N.E. | | 25a DATE REC'D. BY REGISTRAR MAY 26 1980 | 25b REGISTRAR'S SIGNATURE <u>McCreedy</u> |

| | | | |
|--------|--------|---|-------------------|
| Male | Black | 10-23-1934 | 45 |
| Mr. | U.S.A. | | x |
| | | | laborer |
| Mr. | P.O. | Mr. Park | 5626 Coolidge St. |
| George | I. | Proctor, Sr. | Washington |
| No | | 220-20-6297 Joseph Boone-Gane as 13 above | |

Burial 5-23-80 Harmony Mem. Cem. Highland Park, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 13621 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| OPAL | | | M. QUESENBERRY | | | 5.5.80 | | 8:07 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| FEMALE | | WHITE | | NOV. 20, 1924 | | 55 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | |
| Lanham | | Doctors Hospital of P.G. County | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Foster Mother | | P.G. County | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | P.G. Co. | | Bowie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 13e. STREET ADDRESS | | | |
| William W. Mc Millian | | | Bertie M. Arrington | | | 3312 Memphis Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | None | | 235-30-9552 Brenda Smith 9202 Spring Hill La. Greenbelt, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive G.I. bleeding - Cardiac arrest</u> | | | | | | | | | |
| 430- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Berry Anusure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cushing's ulcer</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 4.24.80 | | | Anusure ulcer. G.I. bleeding | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-22-80, 19, to 5-8, 1980, that (I) (we) last saw the deceased alive on 5/5/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE | | | DEGREE | | | 23b. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23c. DATE SIGNED | |
| Dr. Amin Maldonado Jr | | | MD | | | | | 5/5/80 | |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 23e. ADDRESS | | | | | | |
| Dr. Amin Maldonado Jr | | | Doctors Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | May/9/80 | | Maryland National Mem. | | Laurel. P.G. Co., Maryland | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Chambers Funeral Home | | | Riverdale, Maryland | | | MAY 16 1980 | | [Signature] | |

Que. 1. Question

2-2-80

978

08-42-4

04-25-82

100

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 3 6 2 2 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadie S Randolph | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 30, 1980 | | | 2b. HOUR 12:05 PM | | |
| 3 SEX Female | | 4 RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 06 07 89 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Charlottesville, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | |
| 10. CITY OR TOWN OF DEATH Forestville, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Ret. | | |
| 13a. STATE VA. | | | | | 13b. COUNTY ALBEMARLE | | 13c. CITY OR TOWN Charlottesville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FORACE SOLOMON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE HARRIS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 231-70-9940 | | 17. INFORMANT ADDRESS 800 WEST ST. SODIA RANDOLPH, CHARLOTTESVILLE, VA. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASHD CHF | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) heel decubiti | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:28 19 80 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-21 , 19 80 , to 5-30 , 19 80 , that (I) (we) last saw the deceased alive on 5-28 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE W.K. Forest | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-30-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. K. FOREST | | | | | 22e. ADDRESS 9401 TWO MAN HEAD HWY, OXON HILL, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/2/80 | | 23c. NAME OF CEMETERY OR CREMATORY Union Ridge Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Albemarle Co. Va. | | |
| 24. FUNERAL DIRECTOR William Greene | | | | | 814 Franklin Street Alexandria, Virginia | | 25. DATE REC'D. BY REGISTRAR JUN 3 1980 | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

6/2/80 Union Ridge Cem. Liberator Co. Va.

814 Franklin Street
Alexandria, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Mary S. Rattigan | | | 2a DATE OF DEATH MONTH DAY YEAR 5/26/80 | | | 2b HOUR 1:45 PM | | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2/22/98 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | | | | |
| 10 CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Convalescent Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY OWN Home | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE md. | | | 13b COUNTY Howard | | 13c CITY OR TOWN Columbia | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 5158 Evangeline Way | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Vito Scabot | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela R. Crecca | | | 16 ADDRESS Address Same as 13e. | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. 147-039418 | | | 17 INFORMANT Rosemary Eisenhower No# 13e. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIVER Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1552 | | | | | | | | | | | |
| (b) CARCINOMA of Liver | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/24 1980 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-6 1980 , to 5/26 1980 , that (I) (we) lost saw the deceased alive on 5/24 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE David J. Schachter DEGREE D.O. | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED 5/26/80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID Schachter | | | | | | 22e ADDRESS 115 Centerway, Greenbelt Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5-28-80 | | 23c NAME OF CEMETERY OR CREMATORY Greenbelt Historical Cemetery | | | 23d LOCATION CITY OR TOWN COUNTY STATE Greenbelt P.G. Md. | | | |
| 24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | | 25a DATE REC'D. BY REGISTRAR JUN 3 1980 | | 25b REGISTRAR'S SIGNATURE [Signature] | | | |



Female
White
2/23/98
x
Prince George's County
Vito
Secret
R
CROCCO
14100012
Residing at 1500
No

Greenbelt
Historical
Greenbelt
Maryland
2/23/98
x
Prince George's County
Vito
Secret
R
CROCCO
14100012
Residing at 1500
No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 6 2 4 | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | | 2a DATE OF DEATH | | | | 2b HOUR | | | |
| JOHN ESTES REDMAN | | | | May 5, 1980 | | | | 7:40PM | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | 7 UNDER 24 HRS | |
| Male | | White | | May 13, 1899 | | 80 | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | U.S.A. | | | | Prince Georges MD | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Clinton | | Southern Maryland Hospital | | | | | | Fireman, D.C. Gov't Ret. | | | |
| 13a STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Maryland | | | | P.G. | | Marlow Hgts | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6011 Bradley Lane | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Silas E. Redman | | | | FIRST MIDDLE LAST Annie Estes | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| No | | | | ***** | | Mrs. Mary E. Hall, Clinton, Md. Daughter | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostatæ with 185- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastases DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD; Diabetes Mellitus. Congestive Heart Failure | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from January 19, 75, to May 5th, 1980, that (I) (we) lost saw the deceased alive on May 5th, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (d) did not view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | | | 22c DATE SIGNED | | | |
| Victor S. Chupkovich, M.D. | | | | Attending Physician <input type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/> | | | | May 6th/1980 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | | | |
| Victor S. Chupkovich, M.D. | | | | 9131 Piscataway Rd; Clinton, Md. 20735 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 5/8/80 | | Cedar Hill Cemetery | | Sutland P.G. Maryland | | | |
| 24 FUNERAL DIRECTOR'S NAME | | | | 25a DATE RECEIVED BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| Let Funeral Home Inc. | | | | MAY 13 1980 | | | | [Signature] | | | |
| 333 Old Alexander Ferry Road Clinton Md. | | | | | | | | | | | |

101

08\B\c

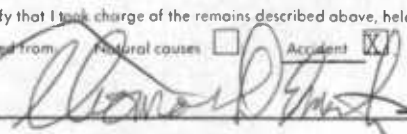
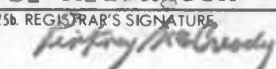
7:10

Item #1 Film G547 9/9/80 re

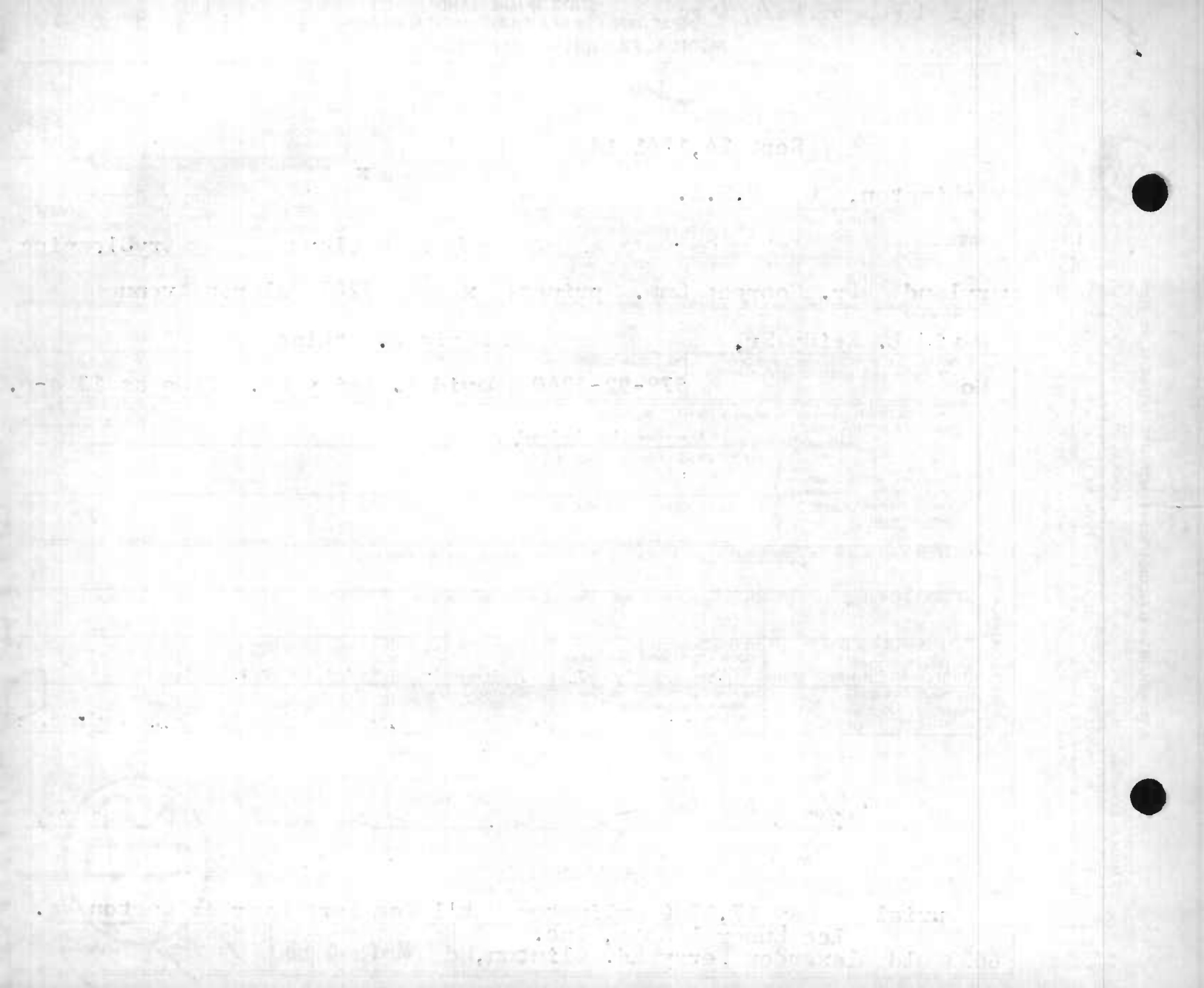
FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 1 3 6 2 5

| | | | | | | | | |
|--|--------|------------------|---|----------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| David Lee Reidy, Jr. | | | DATE KNOWN ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 5 14 1980 | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | |
| Male | White | Sept 24, 1961 | 18 YRS. | MONTHS DAYS | HOURS MIN | 5 14 1980 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Washington, DC | | | U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Cheverly | | | Prince George's General Hospital | | | Clerk | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Pr. Georges Cmp. Springs | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 17. INFORMANT | | |
| David L. Reidy Sr. | | | Marie P. Atkins | | | ADDRESS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 579-92-5240 | | | David L. Reidy Sr. Same as 13 a-e. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Traumatic injuries</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . | | | | | | | | |
| (b) _____ | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) _____ | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | driver in auto/fixed object impact | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | street | | LockRaven Rd nr. McKinley Rd, Camp Springs, P.G. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
|  | | | M.D. Deputy Chief | | | 5/14/80 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| Thomas D. Smith, M.D. | | | 111 Penn St. Balto., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | May 17, 1980 | | Arlington Nat'l Cem | | Fort Myer Arlington Va. | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS | | | MAY 19 1980 | | |  | | |
| Lee Funeral Home, Inc. | | | 6633 Old Alexander Ferry Rd. Clinton, Md | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 3 6 2 6 | |
|--|--|---|--|--|--|--|
| FOR 1- STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | HOUR |
| ELSIE B. RHOADES | | | | | 05 07 80 | 1:00 PM |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | |
| Female | | Black | | MONTH DAY YEAR | | |
| | | | | Mar. 17, 1907 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. AGE (IN YEARS LAST BIRTHDAY) | | |
| Maryland | | USA | | 71 YRS. | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | PRINCE GEORGE'S COUNTY MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Domestic | | | | | | |
| 13a. STATE | | | | | 13b. INSIDE CITY LIMITS? | |
| Maryland | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13c. CITY OR TOWN | | | | | 13d. STREET ADDRESS | |
| Capitol Heights | | | | | 1514 Rollins Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
| Thomas Gantt | | | | | Christiana Stewart | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | |
| no | | | | | 570 28 0508 | |
| 17. INFORMANT | | | | | ADDRESS | |
| 6718 Cling Log Street-Carmody | | | | | Hills | |
| Mrs. Marian Duncan-Daughter | | | | | MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4039 Probable Acute MI & complete heart block | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| (b) Chronic Renal failure, 9p Bowel resection | | | | | | |
| (c) Hypertension. Diabetes mellitus | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| Right lower lobe infarct | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 4.30.80 | | Carcinoma of colon. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5.1.80 to 5.7.1980, that (I) (we) lost saw the deceased alive on 5.7.1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | |
| K. H. MURPHY | | M.D. | | 5.8.80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| K. H. MURPHY | | P.G.G.H. & M.C. CHEVERLY, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | May 13, 1980 | | Harmony Memorial Park | | Landover, Md. |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Stewart Funeral Home-4001 Benning Road, NE. | | | | K. H. Murphy | | |

ELISE B. RUCKER 02 07 80 1:00 PM

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

DEVERLY

no

570 28 0000

570 28 0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jasper Waymon RICE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 19, 1980 | | | 2b. HOUR 2:35 AM | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR April 6, 1925 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS 7b. IF UNDER 24 HRS HOURS MIN | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7d. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD. | | | |
| 10 CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF PR. GEO. CO. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't. Superv. | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. | | 13b. COUNTY N/A | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 639 Brandywine St., S.E. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Rice | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO WW II 579-20-0164 | | 17 INFORMANT ADDRESS Callie Rice-Same as # 13 above | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> 19 <u>80</u> to <u>5/19</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Iradj Sadeghian</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED May 19, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Iradj Sadeghian, M.D. | | | | | 22e. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-21-80 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Md. | |
| 24 FUNERAL DIRECTOR H. S. WASHINGTON | | | | | 25. DATE REC'D. BY REGISTRAR (DATE) MAY 21 1980 | | | | |

Burial

5-21-80

Harmony Mem. Cem. Highland Park, Md.

MAY 1 1980

William

Rice

Bessie

Smith

529-20-0164 Callie Rice-Same as # 13 above

D.C.

N/A

Washington

x

633 Broadway St., S.E.

Gov't. Superv. Retired

Male

Black

April 6, 1922

22

D.C.

U.S.A.

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 6 2 8
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) VIRGINIA | | | 2a DATE OF DEATH MONTH DAY YEAR May 7, 1980 | | | 2b HOUR P 10.10 P M | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR July 20, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS 66 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b CITIZEN OF WHAT COUNTRY? U.S.A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. | | | |
| 10 CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr Geo. Co. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Virginia 13b COUNTY Westmoreland 13c CITY OR TOWN Oak Grove | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS Oak Grove, Va. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Toliver | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Fortune | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO 230-18-1779 | | 17 INFORMANT 6542 Princess Garden Parkway Mrs. Gladys Allen Lanham, Md. 20801 | | | | |

| | | | |
|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH | |
| 4254 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE | | 6 MONTHS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) IDIOPATHIC CARDIOMYOPATHY | | 5 YEARS | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22 I certify that (I) (this hospital) attended the deceased from 11-2- 19 79 , to 5-7- 19 80 , that (I) (we) last saw the deceased alive on 5-7- 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |

| | | | | | |
|---|--|---|--|----------------------------------|--|
| 22a SIGNATURE John Cosma M.D. | | DEGREE | | 22c DATE SIGNED 5-8-80 | |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT) JOHN COSMA, M.D. | | 22d ADDRESS 6776 RACETRACK, BOULE, MD 20715 | | | |

| | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 5/12/1980 | | 23c NAME OF CEMETERY OR CREMATORY Little Zion Bapt. | | 23d LOCATION CITY OR TOWN COUNTY STATE Oak Grove, Va. | |
|---|--|------------------------------|--|---|--|--|--|

| | | | | | |
|--|--|-------------------------------|--|---|--|
| 24 FUNERAL DIRECTOR Eugene W. Little | | 25 DATE MAY 14 1980 | | 26 BY REGISTRAR Barbara McCurdy | |
|--|--|-------------------------------|--|---|--|

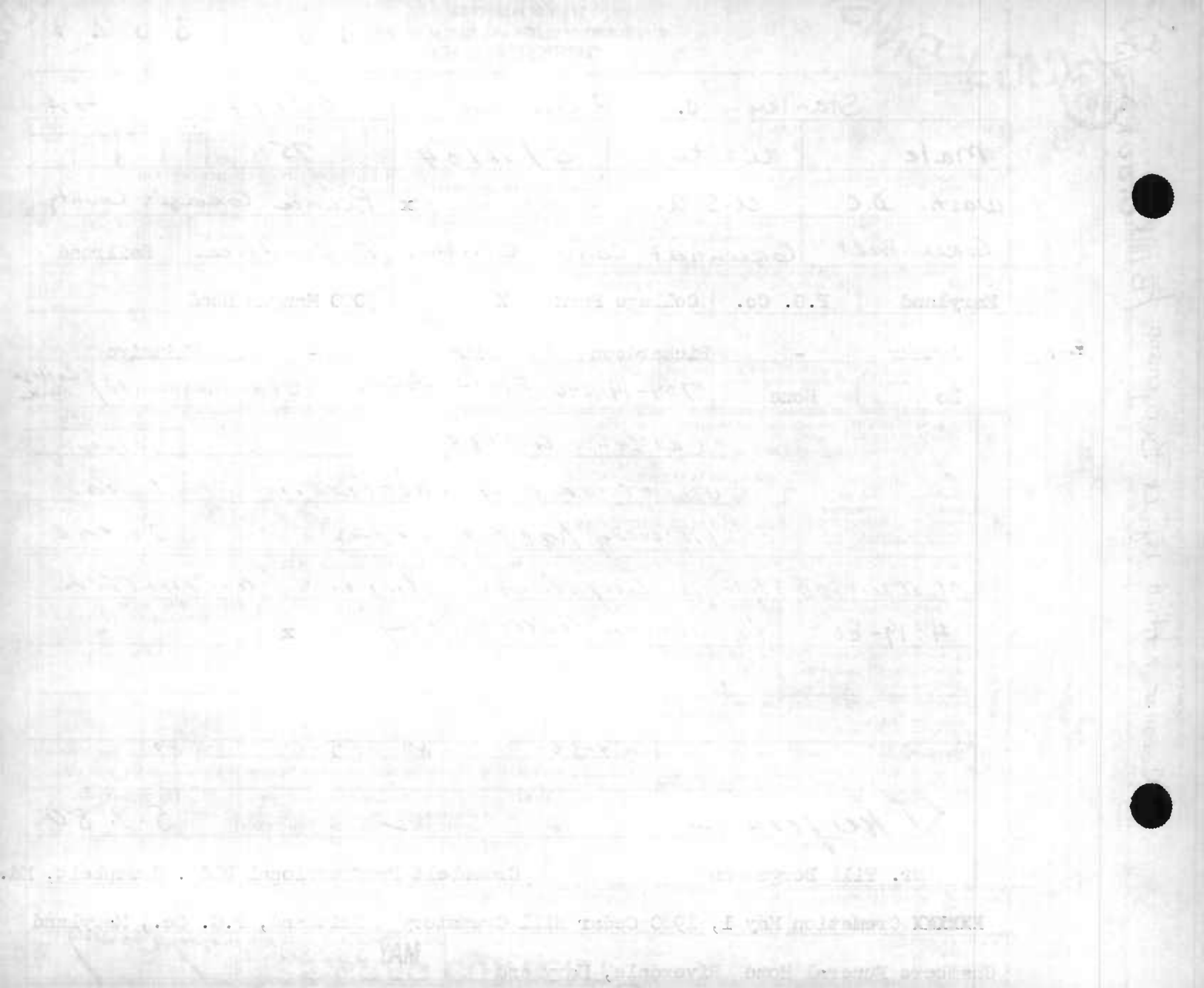
Coroner notified by Dr. Bergemann
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|------------------|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | 7 0 1 3 6 2 9 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | |
| Stanley C. Richardson | | | | | 5/1/80 | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | |
| Male | | White | | 5/18/04 | | 75 YRS. | | 4A M | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Wash. D.C. | | U.S.A. | | | | Prince George's County, MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Greenbelt | | Greenbelt Conv. Center | | R.R. office | | Railroad | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Maryland | | P.G. Co. | | College Park | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5020 Mangum Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Arthur - Richardson | | Rita - Whitmire | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | |
| No | | None | | FLOYD Payne | | 5030 magnum Rd / College Park | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> | |
| 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic heart failure</u> | | | | | | | | 1 year 2 week | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic obstructive lung disease chronic bronchitis</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 4-19-80 | | Malnutrition Feeding gastrostomy | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>80</u> , to <u>5-1</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | | | |
| <u>T. Bergemann</u> | | | | | | 5-1-80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | |
| Dr. Till Bergemann | | Greenbelt Professional Bldg. Greenbelt, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | May 1, 1980 | | Cedar Hill Crematory | | Suitland, P.G. Co., Maryland | | | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | 25a DATE REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Chambers Funeral Home | | Riverdale, Maryland | | MAY 5 1980 | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 0 1 3 6 3 0 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HEIEN RICKER | | | | | 2a. DATE OF DEATH MONTH 5 DAY 24 YEAR 80 | | | | | 2b. HOUR 8:55 P.M. |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 8 DAY 31 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH Largo | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Oper. | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Churchton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5701 Broadwater Parkway | | |
| 14. FATHER'S NAME FIRST Richard MIDDLE Ernest LAST Donaldson | | | | | 15. MOTHER'S MAIDEN NAME FIRST Emily MIDDLE Hortense LAST Martin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 577-01-0042 | | 17. INFORMANT ADDRESS Helen R. Gailing Same as # 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 3320 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) PARKINSONS DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 2 weeks 25 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from SEPT 1978 19 78 , to MAY 25 19 80 , that (I) (we) lost saw the deceased alive on MAY 23 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Neil A. Meade MD | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-25-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil A. Meade | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 28, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. National | | 23d. LOCATION CITY OR TOWN Suitland COUNTY Pr. Geo. STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16,000 Annapolis Rd. Bowie, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | | | | 25b. REGISTRAR'S SIGNATURE |

Burial May 28, 1980 Wash. National
 Beall Funeral Home
 16,000 Annapolis & Bowie, Md.

Suitland Pr. Geo. Mr.

Neil A. Meade

No 577-01-0042 Helen R. Gailing same as # 13

Richard Ernest Donaldson Emily Hortense Martin

Mr. Churchton 2701 Broadwater Parkway

Largo Manor Care Nursing Home Telephone Oper. U.S. Gov't

Wash. D.C. U.S.A. x Prince George

Female Caucasian B 31 1900 79

HELEN KICKER

2 24 80 8:55P



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13632 | | |
|--|--|--|---|---|---|--|--|---|---|--|---------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Baby Male Ross | | | | | May 21 1980 4:30 PM | | | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 21 80 | | | 6. AGE (IN YEARS LAST BIRTHDAY) NB. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS. HOURS MIN 2 57 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Gen. Hosp. | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11320 Bowie Road | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ronnie Victor Everett | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn E. Ross | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 7651 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1:30 PM 5/21</u> , 19 <u>80</u> , to <u>4:30 PM 5/21</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>young s cha H.D</u> | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/21/80</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>YOUNG S CHA M.D</u> | | | | | 22e. ADDRESS <u>P.G.G.H & H.C</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u> | | | 23b. DATE <u>6/18/80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Hospital, Cheverly,</u> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>PG, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Raleigh Cline, Cheverly, Maryland</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUN 25 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

Handwritten signature

JUN 2 1980

(213)

ENCLOSURE

[Faint, illegible text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M/7/77

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13633 | |
|---|-------------------------|--|---|--|---|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) Clyde T. ROWE | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED 5-18-80 | | 2c. DATE PRONOUNCED DEAD 5/18-1980 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 7 DAY 16 YEAR 1963 | 6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS. | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | 10. CITY OR TOWN OF DEATH Chesverly | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZENSHIP USA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 13. KIND OF BUSINESS OR INDUSTRY Erol Shankler, Co | | 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Georges 13c. CITY OR TOWN Riverdale | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE B. LAST Rowe | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE L. LAST Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW11 578-07-8899 | | 17. INFORMANT (daughter) Patricia McMahon-Leadville, Colo. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiac vascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 5-19-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-21-1980 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sil. Spring Montgomery Md | | | |
| 24. FUNERAL DIRECTOR NAME Walter E. Pumphrey ADDRESS 8434 Ga. Ave., S.S. Md | | | | 25. DATE REC'D. BY REGISTRAR MAY 22 1980 | | 26. REGISTRAR'S SIGNATURE Patricia McMahon-Leadville | | | | | |

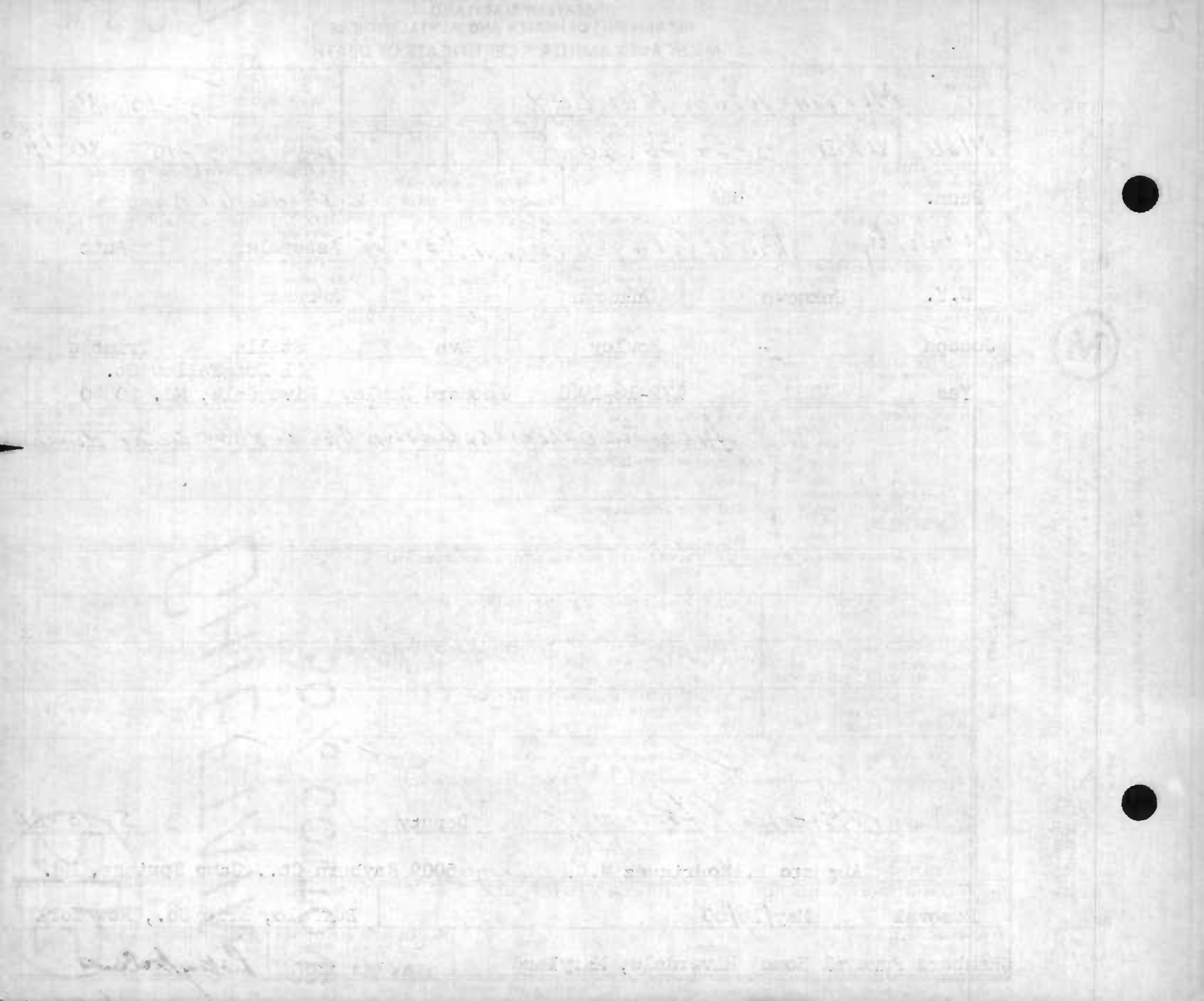
BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE REASON FOR DELAY IN ITEM 1C. RETAIN PAGES 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH OTHER RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

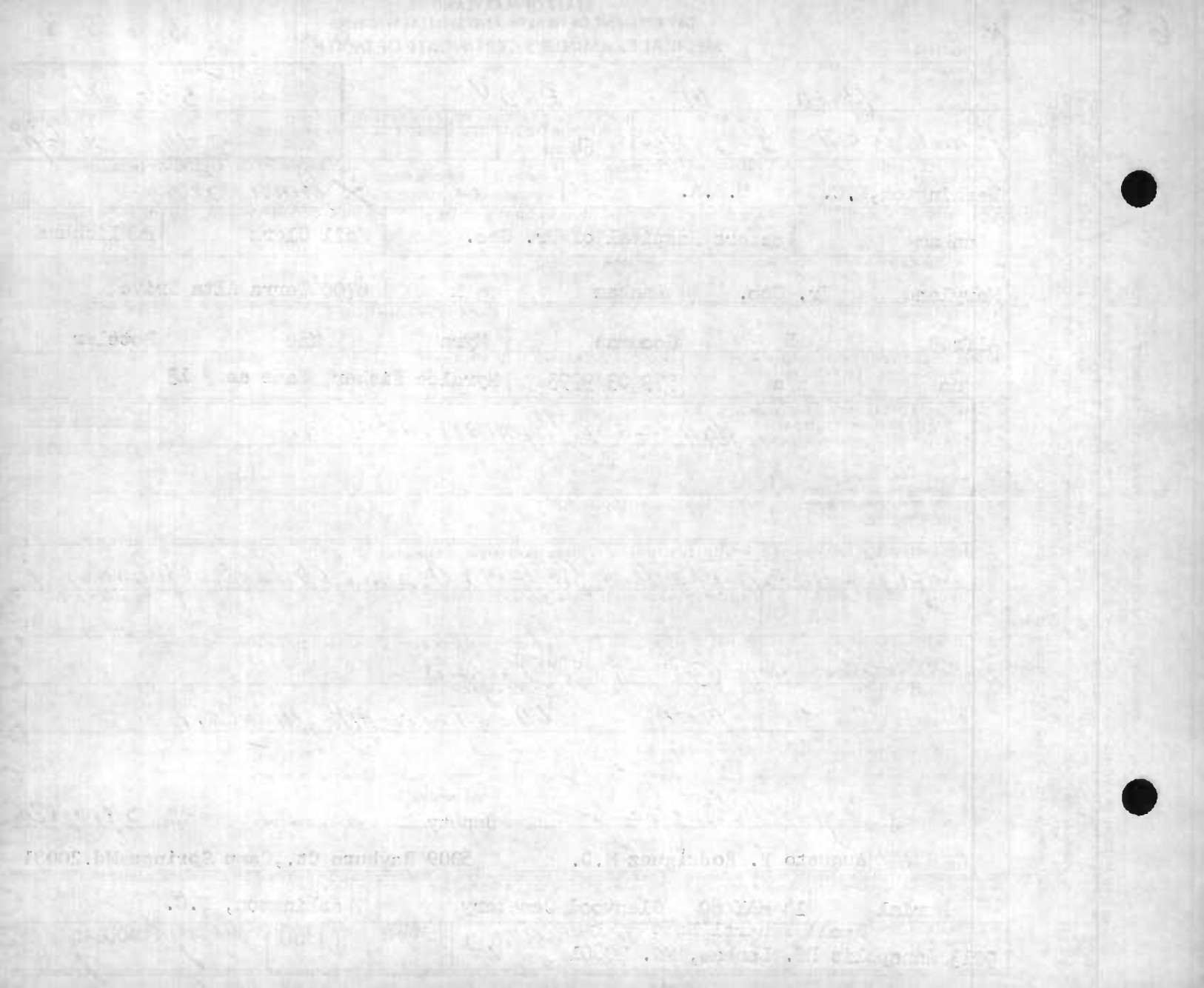
DHMH - 17
(VR A15 ME (5))
15M 7/77

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------------|--|--|--|--|--|---|--|--|--|---|--|---------------|--|--|--|--|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mervin Vernon ROWLEY</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <i>5-15-80</i> | | | | | | | | | | 2b. HOUR M | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>2-24-20</i> | | 6. AGE (IN YEARS) (LAST BIRTHDAY) <i>60</i> YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED <i>DEAD</i> <i>5-15-80</i> | | 2d. HOUR M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penn.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Assembler</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i> | | | | | | | | | |
| USUAL RESIDENCE (IF IN LAUNDRY HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE <i>N.Y.</i> | | 13b. COUNTY <i>Unknown</i> | | 13c. CITY OR TOWN <i>Unknown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>Unknown</i> | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph - Rowley</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eva Stella Trimble</i> | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WW1</i> | | | | 16b. SOCIAL SECURITY NO. <i>172-16-1981</i> | | 17. INFORMANT <i>Leonard Rowley Riverdale, Md. 20840</i> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Arteriosclerosis Complicated Vascular disease</i> 2507 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>Deputy</i> M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>5-15-80</i> | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | | | 23b. DATE <i>May/16/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Buffalo, Erie Co., New York</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Chambers Funeral Home Riverdale, Maryland</i> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 21 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Rickie Adams</i> | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruth M RUDY</i> | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR <i>5-10 1980</i> | | 2b. HOUR <i>6:38 PM</i> | | 3. SEX <i>Female</i> | | | |
| 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>2-25-16</i> | | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <i>64 YRS.</i> | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>5-10 1980</i> | | 7d. HOUR <i>6:38 PM</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Lanham</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctors Hospital of Pr. Geo.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mail Clerk</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Publishers</i> | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Pr. Geo.</i> | | 13c. CITY OR TOWN <i>Lanham</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>6700 Terra Alta Drive</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Alfred B Goodman</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Myra Mae Boteler</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no n/a</i> | | | | | |
| 16b. SOCIAL SECURITY NO. <i>579 03 9993</i> | | 17. INFORMANT ADDRESS <i>Myralee Fisher Same as # 13</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Thromboembolism</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Left hip interior femoral fracture, Chronic obstructive pulmonary disease</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10 P.M. 5-7 1980</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Trepped</i> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6700 Terra Alta North Carro</i> | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | TITLE (SPECIFY) <i>M.D. Deputy</i> | | | | DATE SIGNED <i>5/10/80</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | ADDRESS <i>5009 Rayburn Ct., Camp Springs Md. 20031</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>14 MAY 80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Beall Funeral Home</i> | | ADDRESS <i>9013 Annapolis Rd. Lanham, Md. 20801</i> | | 25a. DATE BY RETURNED BY <i>MAY 19 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Barry McElroy</i> | | | |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 13636

| | | | | | | | | | | | | | |
|--|------------------|--|---|--|-------------------------------|---|--|---|--|--|--|--|--|
| FOR 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13636 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES G. SASSEN | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 25 80 | | 2b. HOUR 1:20 a.m. | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 15-1964 | 6. AGE (IN YEARS) LAST BIRTHDAY 15 YRS. | IF UNDER 1 YR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 25 80 | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 8209--Evelyn Lane | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LeRoy P. Sassen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Crozier | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215 88 6063 | | 17. INFORMANT LeRoy P. Sassen | | ADDRESS 8209--Evelyn Lane Clinton, Md. 20735 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injury</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) <u>stating the underlying cause last.</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 12:10 P.M. 5-24 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of motorcycle lost control | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) at the junction of | | 21f. LOCATION Dangerfiled & Convo St. Clinton, Maryland | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 5-26-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 28, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. | | | | 23d. LOCATION City or Town County State Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. | | ADDRESS 6633 Old Alex. Ferry Rd., Clinton, Md. | | DATE REC'D. BY REGISTRAR JUN 3 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |



11-20-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-7275.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR Home 5/19/80 rc | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothea Schaffer | | | | | | | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | 7a. DATE OF DEATH MONTH DAY YEAR MAY 4 1980 | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH P.G. County MD | | 7b. HOUR 12:15 pm | |
| 10. CITY OR TOWN OF DEATH Clinton, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern MD Hospital Ctr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Charles | | 13c. CITY OR TOWN Waldorf | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5513 Jeffrey Circle | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John C. Bowling | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Yingling | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 205-16-2726 | | 17. INFORMANT ADDRESS Paul W. Schaffer Same as 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF (b) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). GASTROINTESTINAL BLEEDING, SARCIDOSIS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/4 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/4 19 80 , to 5/4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE P. W. | | | | DEGREE MD | | | | 22c. DATE SIGNED 5/4/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE 5/7/80 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Grdns. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles Md. | | | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley | | | | ADDRESS Leonardtwn, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1980 | | 25b. REGISTRAR'S SIGNATURE Robert M. Brady | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 0 1 3 6 3 8 | | REG. NO. | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| ERHARD | | E | | SCHOCKE | | | | 05 11 80 | |
| SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR P M | |
| Male | | White | | Jan. 12 1911 | | 69 | | 10:00 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Germany | | USA | | | | PRINCE GEORGE'S COUNTY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | Ret. Civil Eng. | | WSSC | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Md. | | PG | | Adelphi | | | | 1836 Metzertott Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| UNK | | Margarette Hinz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | 14008 Pond Avenue Rd. S.S.Md. | | | |
| None | | 579 42 7458 | | Mrs. Ute Klingebiel (Daughter) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 585- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Endstage Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> 19 <u>80</u> , to <u>5-11</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>5-9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| RINALDI SINGH | | 4700 Auth Place Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 5/13/80 | | Ft. Lincoln | | Brentwood PG Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hines/ Rinaldi | | F.H. 11800 N.H. Ave. S.S. Md. | | MAY 15 1980 | | | | | |



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SCIENCE

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BOARD

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

MAY 1 1960

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13639 | |
|---|--|-------------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lucy L. SCHUMPERT | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-22 1980 | | 2b. HOUR | | M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1-19-19 | | 6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 5-22 1980 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Chesley | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (GIVE STREET ADDRESS) Anna George General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. STATE Md. | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Bladensburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5804 Annapolis Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Praylow | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Lindsay | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unk | | | | 16b. SOCIAL SECURITY NO. Unk | | 17. INFORMANT ADDRESS Mrs. Dorothy A. View/daughter/1001 Owens Road, Oxon Hill, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Subm. Thromb. embolus DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Extensive Coronary Vascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez M.D. | | | | | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 5-24-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-28-80 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md. | | | |
| 24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St., N.E., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE Robert H. Brady | | | |

11-10-52

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL C. SHUEY | | | 2a. DATE OF DEATH MONTH DAY YEAR May 26 1980 | | 2b. HOUR 7:45 A.M. |
| 3 SEX MALE | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 17 91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Forestville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Churchton |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Shuey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Miller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 07 1836 | | 17. INFORMANT ADDRESS Jeanne Shuey Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 75, to May 19 80, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE WK Quint | | DEGREE MD | | 22c. DATE SIGNED 5-26-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Furst | | 22e. ADDRESS 9401 Indian Head Highway Oxon Hill | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 28 May 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | |
| 23d. LOCATION CITY OR TOWN Brentwood | | COUNTY PG | | STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | ADDRESS Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13641 | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) JAMES Erwin S HULTZ | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 15 80 | | 2b. HOUR M 3:05 a M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6/8/51 | | 6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 15 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Turbine Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY P.E.P.C.O. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Clinton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12301 Chado Ct. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hubert A. Shultz | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elisabeth Klinge | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam | | 17. INFORMANT ADDRESS Cynthia Rae Shultz same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral injury DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 10:25 P.M. MONTH DAY YEAR 5-14- 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of auto/fixed object collision. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Aquasco Rd. Aquasco Prince George's Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 5-16-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/19/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Md. Vet. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home Inc. 6633 Old Alexander Ferry Road Clinton Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Barry McCready</i> | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | |
|--|------------------------------|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Joseph O. Sias</i> | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>5/31 1980</i> | | 2b. HOUR <i>10:30</i> |
| 3. SEX <i>Male</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH <i>12</i> DAY <i>20</i> YEAR <i>20</i> | 6. AGE (IN YEARS) LAST BIRTHDAY <i>59</i> YRS. | IF UNDER 1 YR. MONTHS <i>5</i> DAYS <i>31</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Louisiana</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <i>Chesley (D.C.)</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Prince Georges General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i> |
| 13a. STATE <i>D. C.</i> | | 13b. CITY OR TOWN <i>Washington</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST <i>Joseph E.</i> MIDDLE <i>Sias</i> LAST <i>Sias</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Piola</i> MIDDLE <i>Bastian</i> LAST <i>Bastian</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Not Stated</i> | | 16b. SOCIAL SECURITY NO. <i>438-12-8353</i> | | 17. INFORMANT ADDRESS <i>3306 Lumar Drive</i> <i>Joseph H. Sias, Son, Oxon Hill, Maryland</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | TITLE (SPECIFY) <i>Deputy</i> | | DATE SIGNED <i>5-31-80</i> |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | ADDRESS <i>5009 Rayburn Ct., Camp Springs Md. 20031</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>6 Jun 80</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i> | | 23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i> COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME <i>W. Ernest Jarvis Co., Inc.,</i> | | ADDRESS <i>1432 You St., N.W.,</i> | | DATE REC'D. BY REGISTRAR <i>5-31-80</i> |
| 25a. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8013643 | | | |
|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MADELINE W. SIMPSON | | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 20, 1980 | | 2b HOUR 9:50 P.M. | |
| 3 SEX FEMALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH MONTH DAY YEAR 11 8 09 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) 99/75 CLINTON | | 7b CITIZEN OF WHAT COUNTRY? ✓ | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | |
| 10 CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY At Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN MD. PR. GEO. TEMPLE HILL | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 2805 KERNAL LANE | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William - Bryant | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 1 NO | | 16b SOCIAL SECURITY NO 577-05-0772 | | 17 INFORMANT ADDRESS John W Simpson 5804 Parkling St Temple Hills Md | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic obstructive Pul. Disease (c) Excessive cigarette smoking 40 YRS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 days | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Cerebrovascular accident & Rt. Hemiplegia | | | | | | | |
| 19a DATE OF OPERATION 3/30/80 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) □ | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N.A. | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19 | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/11/80 to 5/20/80, that (I) (we) last saw the deceased alive on 5/20/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. | | | | | | | |
| 22b SIGNATURE Venkat Mani | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 5/21/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) VENKAT MANI | | | | 22e ADDRESS 9015, Woodyard Rd CLINTON Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 5/23/80 | | 23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Clinton Pr. George Md. | |
| 24 FUNERAL DIRECTOR NAME George Phabs F.H. 6160 Wood Hill Rd | | | | 25a DATE REC'D. BY REGISTRAR MAY 23 1980 | | 25b REGISTRAR'S SIGNATURE [Signature] | |

1962 - 1963

1964 - 1965

1966 - 1967

1968 - 1969

1970 - 1971

1972 - 1973

1974 - 1975

1976 - 1977

1978 - 1979

1980 - 1981

1982 - 1983

1984 - 1985

1986 - 1987

1988 - 1989

1990 - 1991

1992 - 1993

1994 - 1995

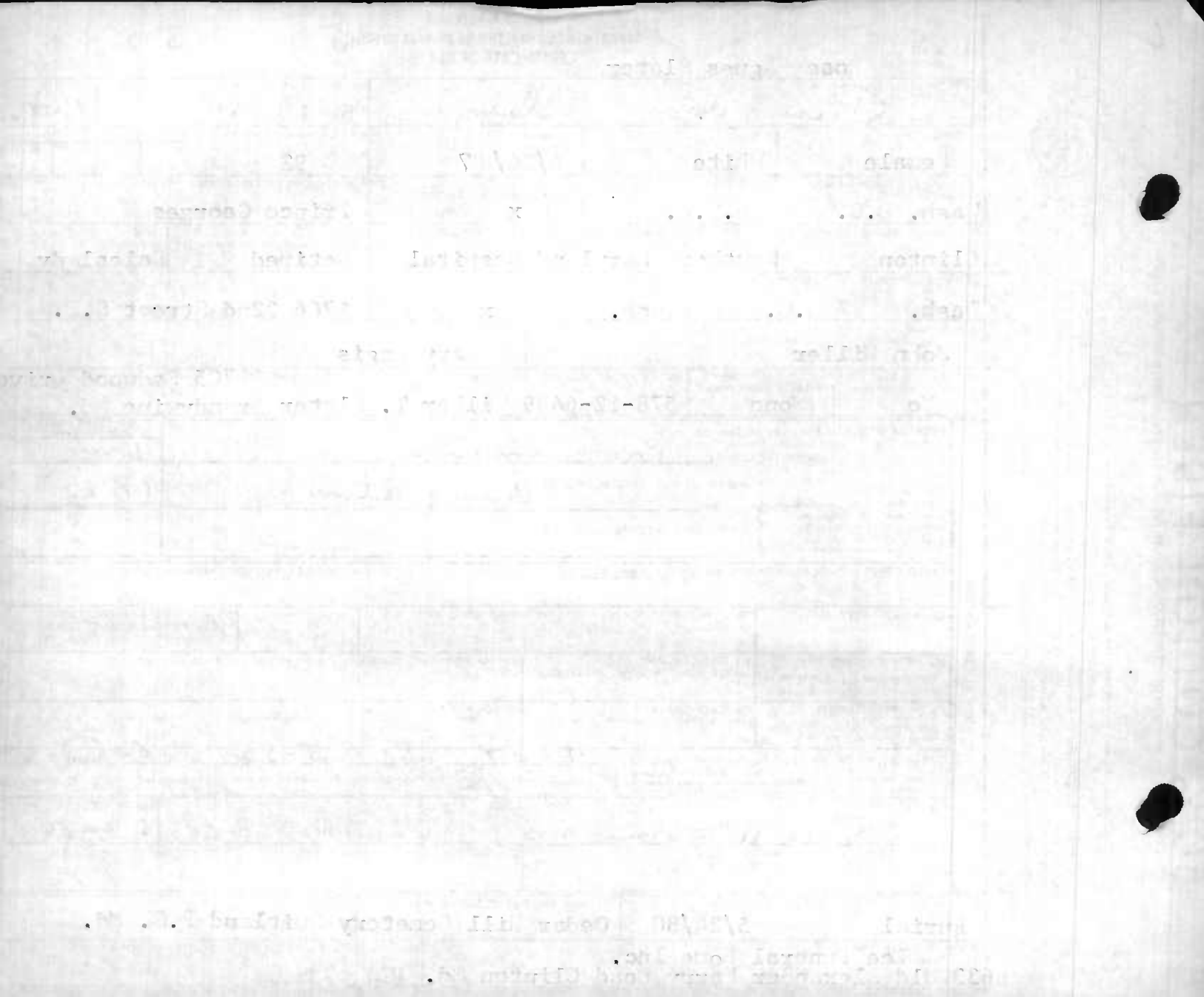
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 3 0 1 3 6 4 4 | |
|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | Rose Agnes Slater | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Rose A. Slater | | | | 5-22-80 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Female | | White | | 6/26/87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Wash. D.C. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Clinton | | Southern Maryland Hospital | | Retired | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | |
| Saleslady | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1706 22nd Street S.E. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Wash. | | D.C. | | Wash. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | |
| John Miller | | Mary Regis | | 578-12-6489 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | 11705 Redwood Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. SOCIAL SECURITY NO. | | 20. DATE OF OPERATION | |
| PART I. DEATH WAS CAUSED BY: | | 578-12-6489 | | 19. 63 | |
| IMMEDIATE CAUSE (a) Carcinoma of | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 1519 | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| DUE TO, OR AS A CONSEQUENCE OF | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| Concussion | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | P.M. 19 | |
| DUE TO, OR AS A CONSEQUENCE OF | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| Concussion | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 22a. I certify that (I) (this hospital) attended the deceased from 4-27-1963 to 5-22-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | |
| | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | 5-22-80 | | C. A. Slater, M.D. | |
| | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| | | | | Burial | |
| | | | | 23b. DATE | |
| | | | | 5/24/80 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | | | Cedar Hill Cemetery | |
| | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | Sutland P.G. Md. | |
| | | | | 24. FUNERAL DIRECTOR NAME | |
| | | | | Lee Funeral Home Inc. | |
| | | | | 25a. DATE REC'D. BY REGISTRAR | |
| | | | | MAY 27 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | [Signature] | |
| | | | | 26. 6633 Old Alexander Ferry Road Clinton Md. | |

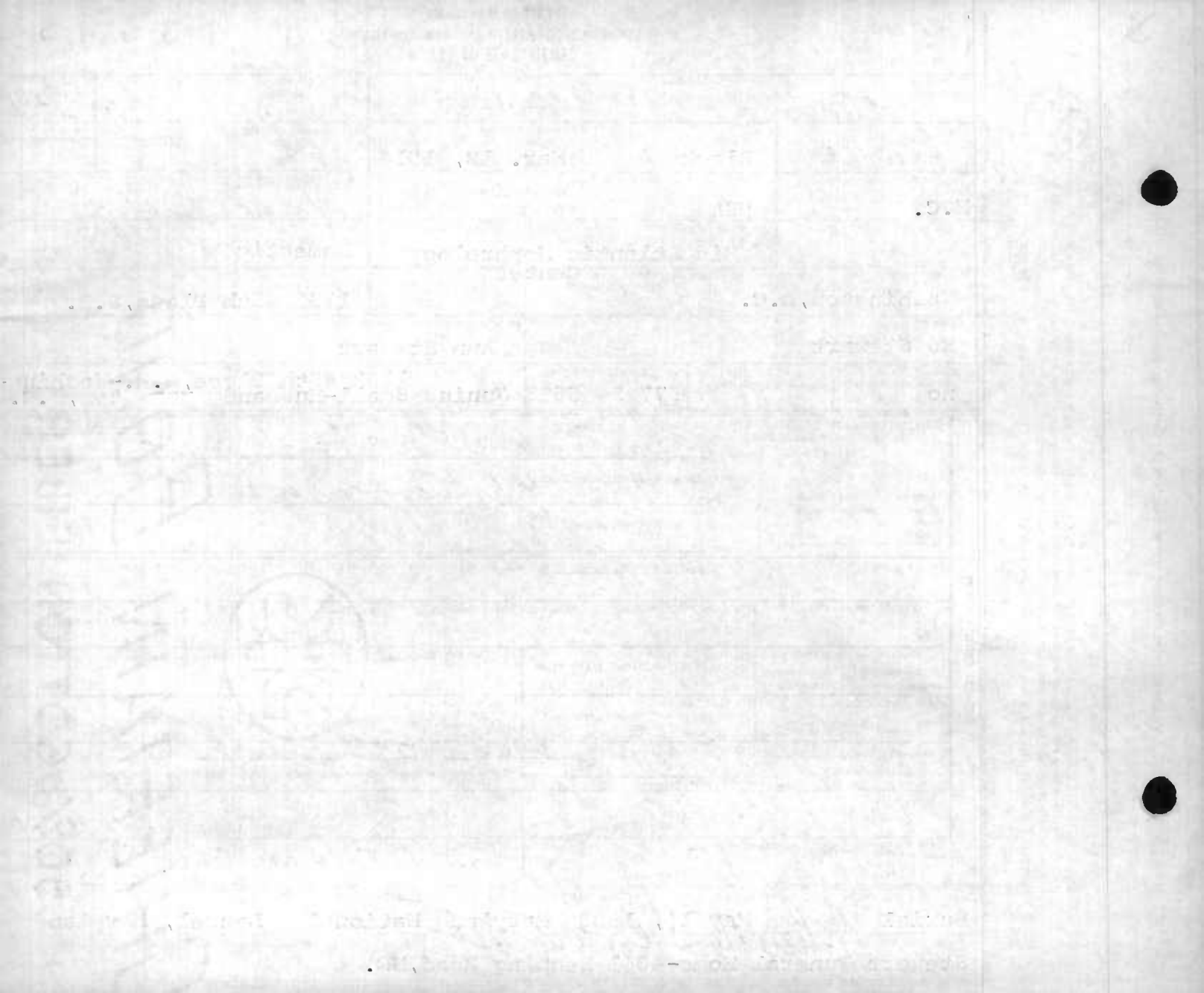


TO HOSPITAL OR ATTENDING PHYSICIAN: The lower requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|--|---|---|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| Christine SMALL | | | | | May 8 1980 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Female | | Black | | Mar. 12, 1914 | | 62 | | 529 ^M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| N.C. | | USA | | | | Prince Georges | | MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| | | Mid Atlantic Nephrology Center | | | | Domestic | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Washington, D.C. | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Ed Stewart | | | | | Ann Stewart | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| no | | | | | 577 34 5623 | | 1152 45th Place, S.E. - Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic End Stage Renal failure | | | | | | | | | | |
| 4275 | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Cardio Pulmonary arrest. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 75, to May 8 19 80, that (I) (we) lost | | | | | | | | | | |
| saw the deceased alive on May 8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death) | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | | |
| Rishpal Singh | | | | | May 8 1980 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| Rishpal Singh | | | | | 4700 Auth Place CAMP SPRING MD 21023 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | May 14, 1980 | | Maryland National | | Laurel, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Stewart Funeral Home-4001 Benning Road, NE | | | | | May 16 1980 | | [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 3 6 4 6 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Julia Elizabeth Smith | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 16 80 | | 2b. HOUR 12:50 P.M. | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 02 23 94 | | 6 AGE (IN YEARS LAST BIRTHDAY) 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Resident Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Apt House | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Wash. D.C. | | | | 13b. COUNTY D.C. | | 13c. CITY OR TOWN Washington | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Theodore Lowe | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 578108229 | | 17 INFORMANT ADDRESS Helen Wells same as 13A | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-15 19 80 , to 5-16 19 80 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE William J. Oetgen, MD | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/16/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J Oetgen | | | | 22e. ADDRESS 3611 Branch ave., Marlo Heights, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 19, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md | |
| 24 FUNERAL DIRECTOR NAME G Gasch's Sons P A | | | | ADDRESS Hyattsville Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Robert [Signature] | | | |

BP

14

Smith Julia E. 19

| | | | | | | | |
|---------|----------------------------|------|------------|------------|------------|------------|------------|
| Female | Caucasian | 52 | 94 | 1919 | Washington | Washington | Washington |
| Clinton | Southern Maryland Hospital | 1919 | Washington | Washington | Washington | Washington | Washington |

Washington

Washington

Washington

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|---|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Orlo D. Snably | | | 2a. DATE OF DEATH MONTH DAY YEAR May 21, 1980 | | | 2b. HOUR 10:30 ^P | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR May 9, 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Mason | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE Maryland | | 13b COUNTY P.G. Co. | | 13c CITY OR TOWN Kent Village | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2408 Virginia Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William - Snably | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie - Rummell | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None | | | 16b SOCIAL SECURITY NO. 578-05-4167 | | | 17 INFORMANT ADDRESS Roxie Catherine Snably (Wife) Same as # 13. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u> <u>185-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> 19 <u>80</u> to <u>5/21</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gabriel B. Jaffe</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED May 22, 1980 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gabriel B. Jaffe, M.D. | | | | | | 22e. ADDRESS 5711 Savis Ave. Riverdale, Maryland 20840 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May/24/80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Co., Maryland | | |
| 24 FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | | | ADDRESS Riverdale, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 26 1980 | |
| 25b. REGISTRAR'S SIGNATURE <u>Robert McCready</u> | | | | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2700 BP

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 3 6 4 8 | | | |
|---|--|---|--|--|--|--|--|-----------------------------------|--|---|-------|-------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) BETTY Jane SOUDERS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 10 80 | | | 2b. HOUR 10:50 AM | | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Nov 14 1933 | | 6 AGE (IN YEARS LAST BIRTHDAY) 46 | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. CITY OR TOWN Pr Geo. | | 13c. STREET ADDRESS Capitol Hgts | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Worley J Hood | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lee Moore | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT Julian E. Souders | | | | ADDRESS Same as #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>three years</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 minutes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 19 <u>80</u> , to <u>May 10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stuart E. Selonick, M.D.</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/10/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D. | | | | 22e. ADDRESS 5225 Pooks Hill Rd - Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 13 May 80 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem | | 23d. LOCATION CITY OR TOWN Clinton | | COUNTY Maryland | | STATE | | | |
| 24 FUNERAL DIRECTOR'S NAME Robert E Wilhelm Suitland Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u> | | | | | | | |

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03 10 80 10:50

SOUDERS

BETTY

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

2
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 4 9

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) LINDSAY NATHANIEL STAMPLEY | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 6 1980 | | | 2b HOUR 6:30A M | | | | |
| 3 SEX MALE | | 4 RACE NEGRO | | 5 DATE OF BIRTH MONTH DAY YEAR FEBRUARY 6 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK | | 12b KIND OF BUSINESS OR INDUSTRY MILITARY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | | | 13b COUNTY PRINCE GEO | | 13c CITY OR TOWN BRANDYWINE | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ALBERT JOHN STAMPLEY | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OCTAVIA BROWN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 547-42-8851 | | | 17 INFORMANT ADDRESS Mildred S. MARTIN(SISTER) SAME AS 13 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- CVA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 5 May 19 80, to 6 May 19 80, that (I) (we) lost saw the deceased alive on 6 May 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE JBC ccc | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 6 May 80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) RODRIGO B. CADIZ, M.D. | | | | | 22e ADDRESS 3489 MENC AAFB MD 20331 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5/12/80 | | 23c NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery | | | 23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland | | |
| 24 FUNERAL DIRECTOR NAME Martell Adams Aquasco, Maryland 20608 | | | | | 25a DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b REGISTRAR'S SIGNATURE [Signature] | | | |

| FOR 1 - STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | 8 0 1 3 6 5 0 | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Catherine J. Stevens</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5 11 80</i> | | | | 2b. HOUR <i>10⁵⁰ AM</i> | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 5 1887</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGE MD.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH <i>HYATTSVILLE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY GIVE STREET ADDRESS) <i>CAREGGH MANOR</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOME</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <i>MD. PAH Hyattsville</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS <i>MARKET ST.</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Johnson</i> | | 15. MOTHER'S MARRIAGE NAME FIRST MIDDLE LAST <i>MARY SHAVIN</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>214 05 0051</i> | | 17. INFORMANT ADDRESS <i>Catherine Griffin 5517 Southwick St. Bethesda, MD.</i> | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease & Congestive Failure</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <i>10 months / 5 years</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19__ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-27-</i> 19 <i>79</i> , to <i>5-11</i> 19 <i>80</i> , that (I) (<u>we</u>) lost saw the deceased alive on <i>5-10</i> 19 <i>80</i> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Thomas F Collins M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>5-11-80</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS F. COLLINS MD</i> | | | | 22e. ADDRESS <i>2609 Greeno Chapel Rd Hyattsville Md 20782</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (PRECISY) <i>Burial</i> | | 23b. DATE <i>5/13/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hyattsville Md PA MD</i> | | | | | |
| 24. FUNERAL DIRECTOR (NAME) ADDRESS <i>John M. L. Lister Annapolis md.</i> | | | | 25. DATE REC'D. BY REGISTRAR <i>MAY 15 1980</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

STEVEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Julia C. Stiles | | | 2a. DATE OF DEATH Month May Day 24 Year 1980 | | | 2b. HOUR 8:55 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Jan. 3, 1887 | | 6. AGE (In years last birthday) 93 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) England | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Pr. Geo. Co. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5703 Carlyle Street | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Corsetteier | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Cheverly | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Charles Middle Stiles Last Stiles | | 15. MOTHER'S MAIDEN NAME First Elizabeth Middle Hempsted Last Hempsted | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 387-05-8918A | | 17. INFORMANT Josephine H. Coster | | Address Address Same as No# 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) congestive Heart failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) no | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) no | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1978 to May 24, 1980 , that (I) (we) last saw the deceased alive on May 22, 1980 , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE AK Bowie | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED May 24 1980 | |
| 22d. PHYSICIAN'S NAME (Type) AK BOWIE | | | | 22e. ADDRESS 301 Consolidation Wash DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-27-80 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Brentwood, P.G. Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | 25a. REC'D BY REGISTRAR MAY 28 1980 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Brady</i> | |

May 21, 1964

Office

Wash.

Jan. 7, 1962

Wash.

Wash.

Mr. Sen. J.

Wash.

Cor. ation

Wash.

Wash.

Wash.

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X

Wash.

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Wash.

[Faint, illegible handwritten notes and signatures]

[Faint, illegible handwritten notes and signatures]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 1 3 6 5 2 | | | |
|--|--|--|---|--|------------------------------------|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR P M | | | | |
| WILMER R. STITELY | | | | | | 05-25-80 | | | 7:30 P M | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| Male | | White | | June 10, 1903 | | 76 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Maryland | | U.S.A. | | | | PRINCE GEORGE'S | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | | | | | Chief Clerk | | Government | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. CITY OR TOWN | | | | 13b. STREET ADDRESS | | | | | |
| 13a. STATE 13b. COUNTY | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS | | | | | |
| Maryland P.G. | | | | College Park | | | | 9404 48th. Avenue | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Cartie Stitely | | | | Annie Lookingbill | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT (Wife) ADDRESS | | | | | | | | | |
| No | | None | | 577-60-2070 | | Lois V. Stitely | | SAME AS #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i> | | | | | | | | | | <i>immediate</i> | | | |
| 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Failure</i> | | | | | | | | | | <i>6 mos</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cryptogenic Cirrhosis</i> | | | | | | | | | | <i>18 mos</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/20</i> 19 <i>80</i> , to <i>5/25</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>5/24</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>V. Drant</i> | | | | | | DEGREE | | | 22c. DATE SIGNED <i>5/26/80</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| D. Granite, MD | | | | | | 115 Centerway Greenbelt Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | May 28, 1980 | | Geo. Washington Cem. | | | Adelphi P.G. Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave. Silver Spring, Md. | | | | MAY 29 1980 | | <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

7.3.5

05-23-40

CHITLY

R.

WILMER

PRINCE GEORGE'S

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVERLY

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. PAGES 7, 8, AND 9 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2

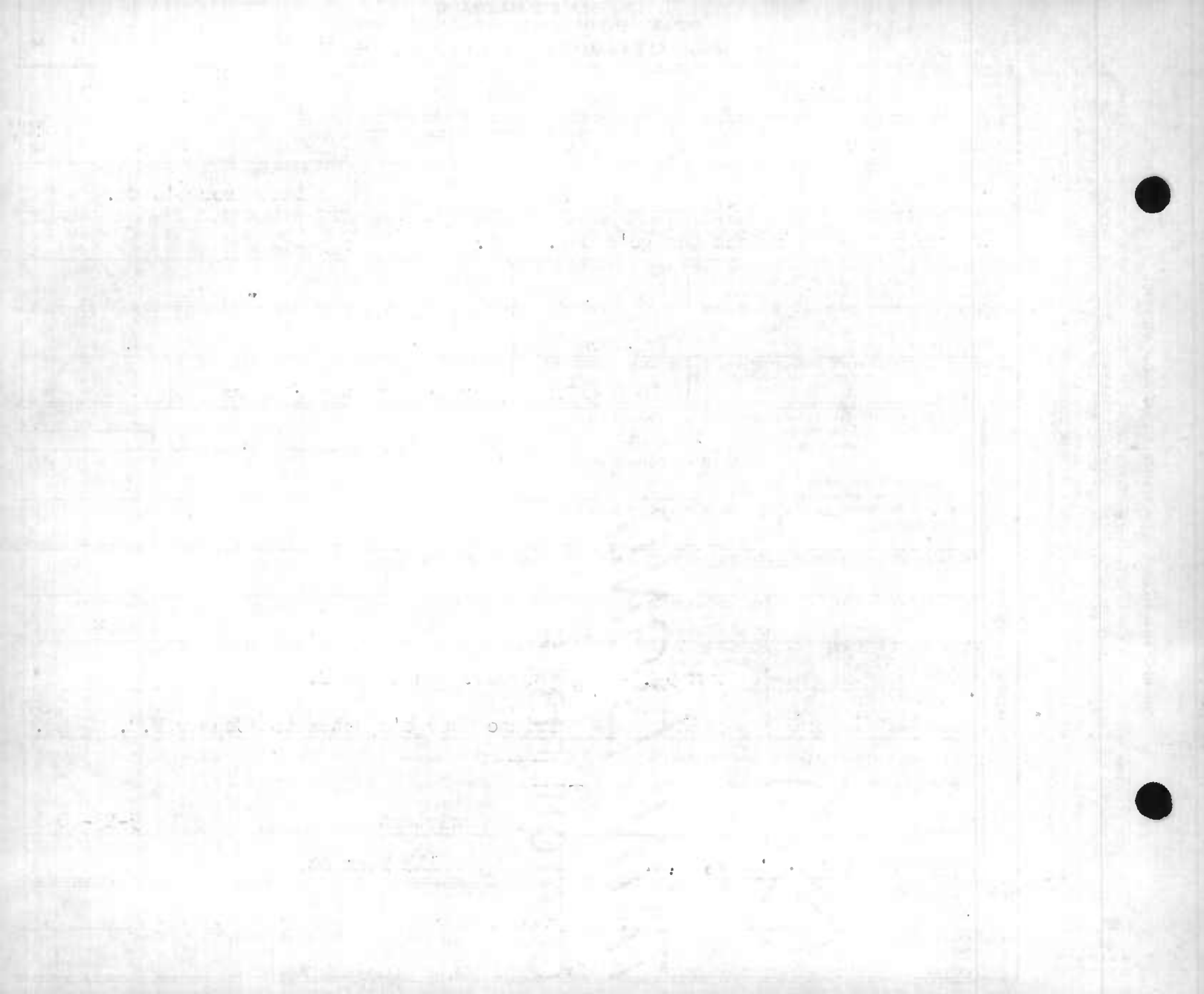
DHMH - 17
(VR A15 ME (5))
30M 7/73

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|--|--|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST KENNETH | | MIDDLE SUGGS | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED MONTH 5 DAY 23 YEAR 80 | | 2b. HOUR a.m. 6:00 | | | | | | | |
| 3. SEX male | | 4. RACE negro | | 5. DATE OF BIRTH MONTH DAY YEAR 4 - 4 - 55 | | 6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | 9. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 23 80 | | 24. HOUR a.m. 6:00 | | | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 13. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. | | | | | | | |
| 14. CITY OR TOWN OF DEATH Cheverly | | | | 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. | | | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | | | 17. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a. STATE Maryland 18b. COUNTY Prince Georges 18c. CITY OR TOWN Oxon Hill | | | | | | | | | | | | 19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20. STREET ADDRESS 1101 South View Drive, | | | |
| 21. FATHER'S NAME FIRST MIDDLE LAST Lincoln Waters | | | | | | 22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Suggs | | | | | | | | | | | | | |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 24. SOCIAL SECURITY NO. 578-76-5326 | | | | 25. INFORMANT ADDRESS Emily Darden - Same as Item #13e | | | | | | | | | | | |
| 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 27. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 28. DATE OF OPERATION | | | | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 30. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 31. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 32. TIME OF INJURY HOUR A.M. MONTH DAY YEAR xxx 5-23- 80 | | | | 33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self. | | | | | | | | | | | |
| 34. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 35. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jail | | | | 36. LOCATION STREET CITY OR TOWN COUNTY STATE Prince George's Detention Center, P.G. Md. | | | | | | | | | | | |
| 37. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| 38. ACTUAL SIGNATURE _____ M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5-23-80 | | | | | | | | | | | | | | | | | | | |
| 39. EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 41. DATE 5-29-80 | | 42. NAME OF CEMETERY OR CREMATORY Harmony Mem. Cemetery | | | | 43. LOCATION CITY OR TOWN COUNTY STATE Landover, Md. | | | | | | | | | |
| 44. FUNERAL DIRECTOR NAME ADDRESS Vann & Williams Funeral Home 4804 Ga. Ave., N.W. | | | | | | | | 45. DATE REC'D. BY REGISTRAR MAY 29 1980 | | | | 46. REGISTRAR'S SIGNATURE R. H. [Signature] | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|------------------------------|---|---|---|---|----|--|-----------------------------------|---|--|-----------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| AGNES Marie SWEENEY | | | 05 | | 09 | | 80 | | 5:45A.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | |
| Female | | Caucasian | | MONTH 09 DAY 19 YEAR 05 | | 74 | | MONTHS | | DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | Prince Georges MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Clinton | | | Southern Maryland Hospital Center | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Prince Geo. | | Clinton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 9211 Stuart Lane | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST Francis Hurley Cusic | | | | | FIRST MIDDLE LAST Laura Frances Hall | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | | | | | James W. Sweeney Mechanicsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic shock and arrhythmias</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiopulmonary failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lymphoma and Diabetes mellitus.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 2, 1980</u> to <u>May 9, 1980</u> , that (I) (we) lost saw the deceased alive on <u>May 8, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>M. NEMAT</u> | | | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 5/9/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| M. NEMAT, M.D. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | May 12, 1980 | | St Johns | | | | Hollywood, St Mary's, Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| W. Clarke Mattingley Leonardtown, Maryland | | | | | | | | MAY 13 1980 | | <u>Robert M. Brady</u> | | | |



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 5 5

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) LAVINIA ESTHER TALLMAN | | | 2a DATE OF DEATH MONTH DAY YEAR May 19, 1980 | | | 2b HOUR 9:30PM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mo. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10 CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of P.G. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b KIND OF BUSINESS OR INDUSTRY Teaching | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE Maryland | | 13b COUNTY P.G. | | 13c CITY OR TOWN Bowie | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 3111 Tinder Place | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Robertson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Sayle | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b SOCIAL SECURITY NO. IF YES, GIVE WAR OR DATES 488-68-5386 | | 17 INFORMANT ADDRESS Bowie John B. Tallman, 3111 Tinder Pl., Md. | | | | |

| | | | |
|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Chronic Angerthle heart failure wth evidence</i> 586- DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerotic heart disease. P. Chbts mld</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal failure</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>5/10</i> 19 <i>80</i> to <i>5/19</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>5/19</i> 19 <i>80</i> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <i>Paul Radwin</i> | | | | DEGREE <i>MD</i> | | 22c DATE SIGNED <i>5/20/80</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>TSUNIZ</i> | | | | 22e ADDRESS <i>6201 Greenbelt Rd. Calver Park Md.</i> | | | |

| | | | | | |
|--|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION (SPECIFY) Cremation | | 23b DATE May 23, 1980 | | 23c LOCATION Metropolitan Crematory Alexandria, Virginia | |
| 24 FUNERAL HOME Robert G. Beall Funeral Home | | 25a DATE REC'D. BY REGISTRAR MAY 26 1980 | | 25b REGISTRAR'S SIGNATURE <i>Barbara McCready</i> | |
| 16000 Annapolis Road, XXXXXX Bowie, Md. | | | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

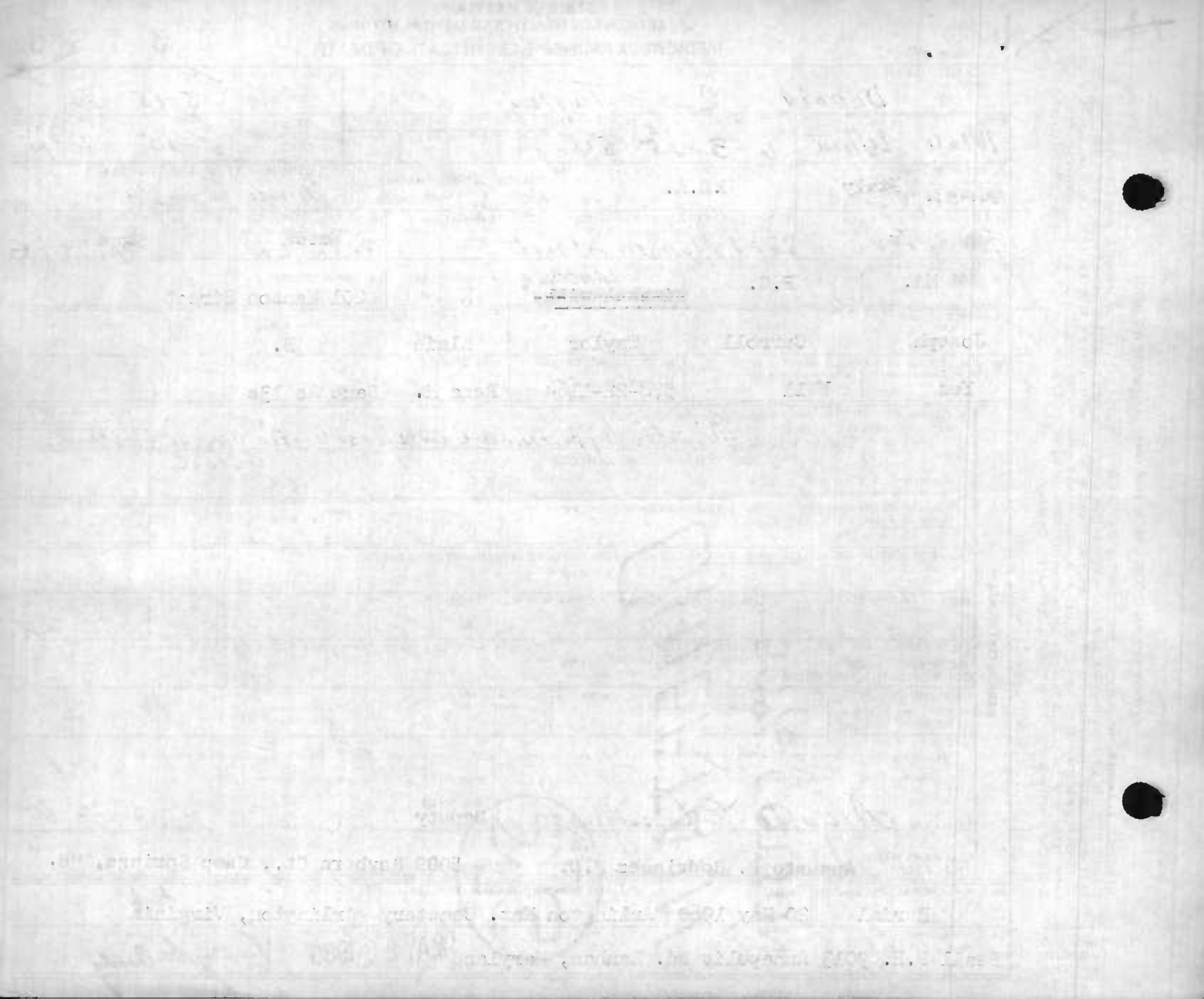
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTERARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13656

| | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| Donald C. Taylor | | | | | | | | MONTH DAY YEAR 5-15 1980 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 6-3-25 | | 54 YRS. | | MONTHS DAYS | | HOURS MIN | | 5-15 1980 | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | |
| WASH. D.C. | | U.S.A. | | WIDOWED | | DIVORCED | | Prince Georges | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Landover | | 2201 Manson Street | | PRINTER | | PRINTING | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | P.G. | | Landover | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8201 Manson Street | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | |
| Joseph | | Carroll | | Taylor | | Elsie | | B. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | WWII | | 578-22-1164 | | Rena M. | | Same As 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 2507 | | IMMEDIATE CAUSE (a) | | Diabetic hypotensive atherosclerotic cardiovascular disease | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | (b) | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | Augusto P. Rodriguez | | TITLE (SPECIFY) | | Deputy | | MEDICAL EXAMINER | | DATE SIGNED | | 5-15-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Augusto P. Rodriguez M.D. | | ADDRESS | | 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Burial | | 20 May 1980 | | Arlington Nat. Cemetery | | Arlington, Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | F.H. | | 9013 Annapolis Rd. Lanham, Maryland | | MAY 22 1980 | | [Signature] | | | | | |



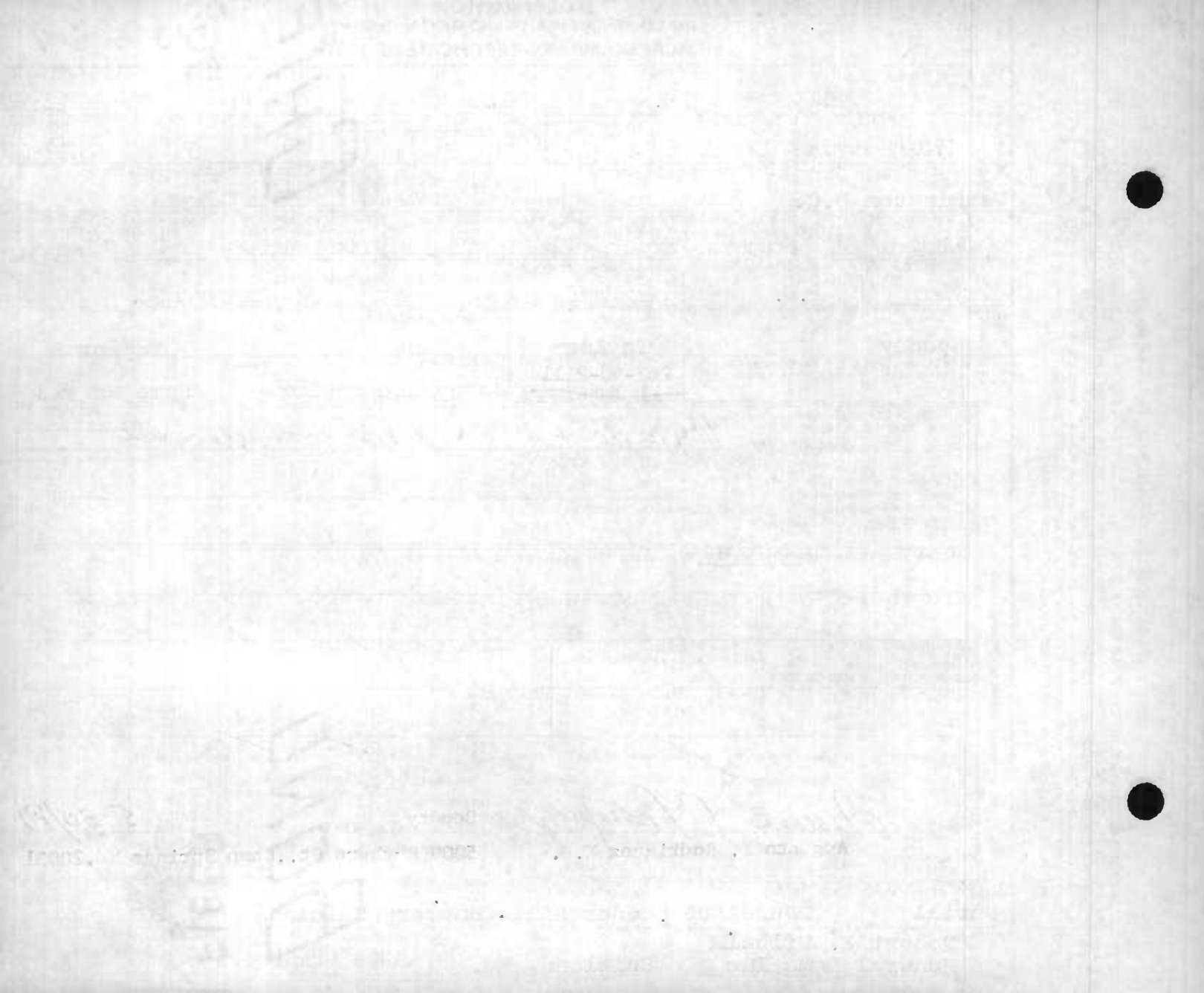
10

| | | | | | | | | | |
|---|-----------|---|-------------------|--|---------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| LESLIE L. TAYLOR | | | | 5 30 1980 | | 12:58A | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | Caucasian | 12 1 1930 | 49 YRS. | | | 5 30 1980 | | 12:58A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington D.C. | | USA | | | | Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clinton | | Southern Maryland Hospital Center | | | | Lowe Pontiac | | Car Salesman | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | P.G. | | Upper Marlboro | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 6523 Rosemont St. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | |
| Sydney Taylor | | | | Edna Taylor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | 262-40-2111 | | Josephine Taylor | | Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 19c. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> | | | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 5-30/80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| Burial | | 2 June 1980 | | Cedar Hill Cemetery | | Suitland | | PG Md | |
| 24. FUNERAL DIRECTOR NAME (TYPE OR PRINT) Robert E. Wilhelm | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Funeral Home Inc | | | | JUN 4 1980 | | <u>Jeffrey McBrady</u> | | | |
| | | | | Suitland, Md. | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1205 BP
 DHMH - 17
 (V.R. 15 ME (5))
 15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 0 1 3 6 5 8 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie A. Tichnell | | | | 2b. DATE OF DEATH MONTH DAY YEAR May 14 1980 | | | |
| 3 SEX Female | | | | 2b. HOUR 6:30a. M | | | |
| 4 RACE White | | | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 | | | |
| 5 DATE OF BIRTH MONTH DAY YEAR April 13, 1896 | | | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | |
| 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator | | | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Prince Geo. | | | |
| 13c. CITY OR TOWN University Pk | | | | 13d. STREET ADDRESS 4206 Sheridan Street | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Francis McDermott | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Louise Walter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578 26 1329A | | | |
| 17 INFORMANT ADDRESS Robert S. Tichnell Same as #13 (Son) | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c): 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> 19 <u>80</u> to <u>5/14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>John Melnick</u> DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-14-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Melnick, M. D. | | | | 22e. ADDRESS 4404 Queensbury Road, Riverdale, Md. 20840 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/17/80 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24 FUNERAL DIRECTOR'S NAME Francis Gasch's Sons | | | | 24b. ADDRESS Funeral Home, P.A. Hyattsville, Maryland | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 3 6 5 9 | |
|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) ELIZABETH TORNIUS | | | 2a DATE OF DEATH MONTH DAY YEAR 05-12-80 | | 2b HOUR 5:40P M |
| 3 SEX Female | 4 RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 28 1898 | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Estonia | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY Home |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | 13b COUNTY P.G. | 13c CITY OR TOWN Greenbelt | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jyri Loigu | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mai -- Lill | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | 17 INFORMANT ADDRESS 148-26-7480-D Piret Kork 117 Julian Ct. Greenbelt, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intia cerebral hemorrhage</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>May 1st</u> 19 <u>80</u> to <u>May 12th</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5.12.</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Konappa H. Murthy</u> | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 5/13/80 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) KONAPPA MURTHY M.D. | | | 22e ADDRESS PGGH/MC, CHEVERLY, MARYLAND | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 17 May 1980 | 23c NAME OF CEMETERY OR CREMATORY Kensico Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Valhalla New York | |
| 24 FUNERAL DIRECTOR NAME Beall F.h. 9013 Annapolis Rd. Lanham, Maryland | | | 25a DATE REC'D. BY REGISTRAR MAY 20 1980 | | 25b REGISTRAR'S SIGNATURE <u>Konappa H. Murthy</u> |

3:40P 02-19-78 TUESDAY JEFFERSON

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CLEVELY

2/12/80

X

PGCHMC, CLEVELY, MARYLAND

KONAPPA MURTHY M.D.

APR 11 1980



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13660 | | | |
|---|--|---------------|--|---|--|---------------------------------|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice Lee Tucker | | | | | | | | | | ESTIMATED 5-28 1980 | | M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3-15-94 80 YRS. | | 6. AGE (IN YEARS) LAST BIRTHDAY | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD 5/28 1980 | | 7d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital | | | | 12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 6613-POWHATTAN ST | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY RIVERDALE | | | | 13c. CITY OR TOWN | | | | 13d. STREET ADDRESS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John GORE | | | | | | | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST MARTHA ARNOLD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, INDICATE BRANCH AND DATES) NO | | | | 16b. SOCIAL SECURITY NO. 242 14 9311 D | | | | 17. INFORMATION 6613-POWHATTAN ST - DAUGHTER MRS THELMA ROBINSON | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic arteriosclerosis and vascular disease 2507 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) M.D. August | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-29-80 | |
| EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ | | | | ADDRESS 5009 Rayburn Court, Langley Springs, Md. 20631 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC. DATE | | | | 23b. NAME OF CEMETERY OR CREMATORY | | | | 23c. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial-Removal Jun 21 1980 | | | | Beechwood Cemetery | | | | Durham, N.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME John Stewart | | | | ADDRESS 4001 Benning Road, NE. | | | | 25. BY REQUEST | | | | 26. BY REQUEST | |

10



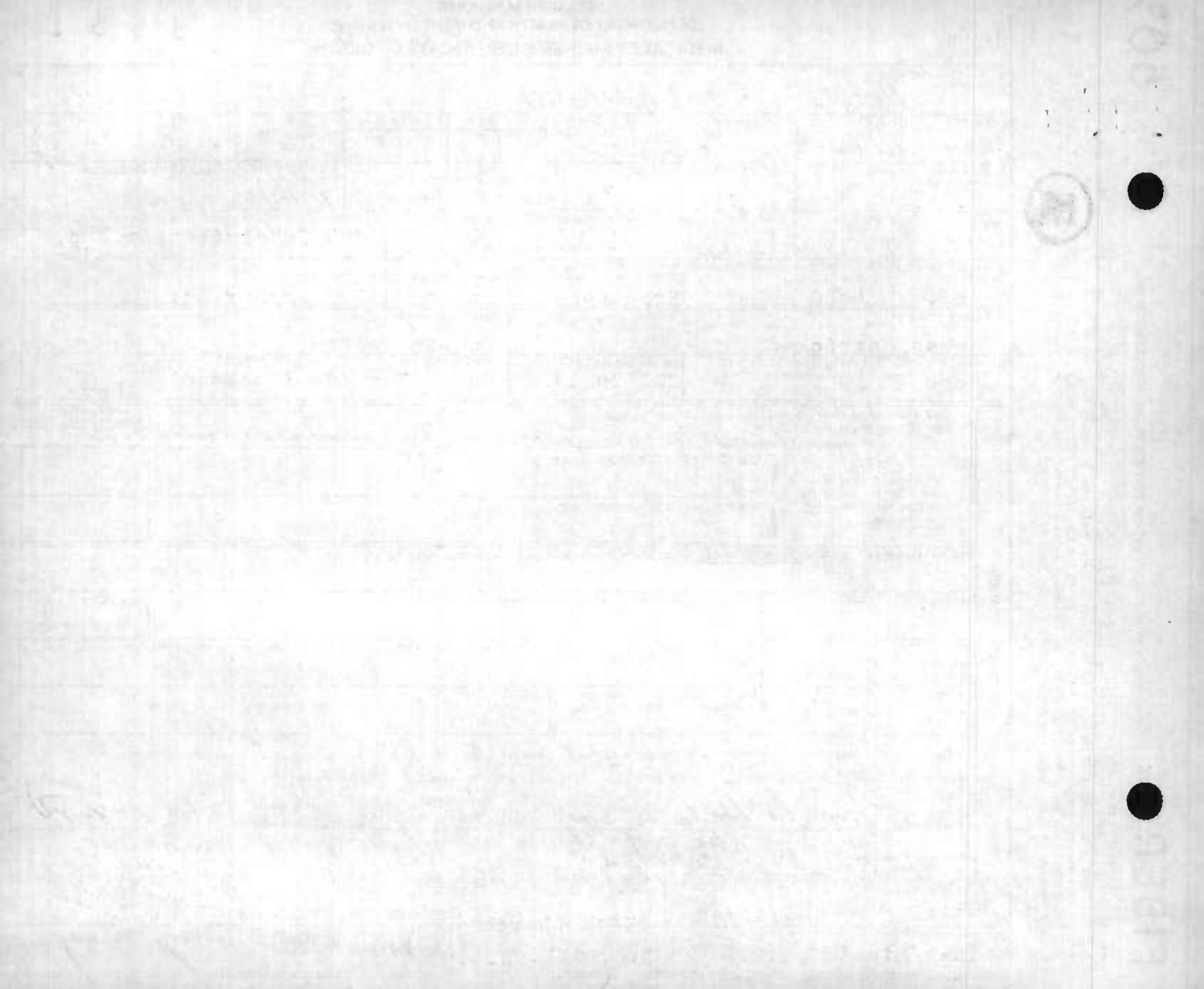
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DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 1 3 6 6 1 REG. NO. | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Decota B. VARNADO</i> | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 <i>5-9</i> 80 | | 2b. HOUR M <i>3:30</i> AM | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>4-20-23</i> | | 6. AGE (IN YEARS) (LAST BIRTHDAY) <i>57</i> YRS. | | 7. DATE PRONOUNCED DEAD <i>5-9</i> 19 <i>80</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD | | | |
| 10. CITY OR TOWN OF DEATH <i>Chesley</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bank Supervisor</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Am. Sec. Trust</i> | |
| USUAL RESIDENCE, IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS <i>3705 Upshur St.</i> | | | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>PG</i> | | 13c. CITY OR TOWN <i>Brentwood</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fannie Wegman</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Barrickman</i> | | | | 17. INFORMANT ADDRESS <i>Same as Above</i> <i>Damon Varnado (Husband)</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>None</i> | | 16b. SOCIAL SECURITY NO. <i>212 20 1324</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic cardiovascular disease</i> <i>2507</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | MEDICAL EXAMINER DATE SIGNED <i>5-9-80</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i> | | ADDRESS <i>5609 Bayview Court Camp Springs Md 20746</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5/12/80</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Brick Church Cemetery</i> | | 23d. LOCATION CITY OR TOWN <i>Huttonsville, W. Va.</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi F.H.</i> | | | | | | 25a. DATE REG'D. BY REGISTRAR <i>MAY 15 1980</i> | | 25b. REGISTRAR'S SIGNATURE <i>Harry M. Brady</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

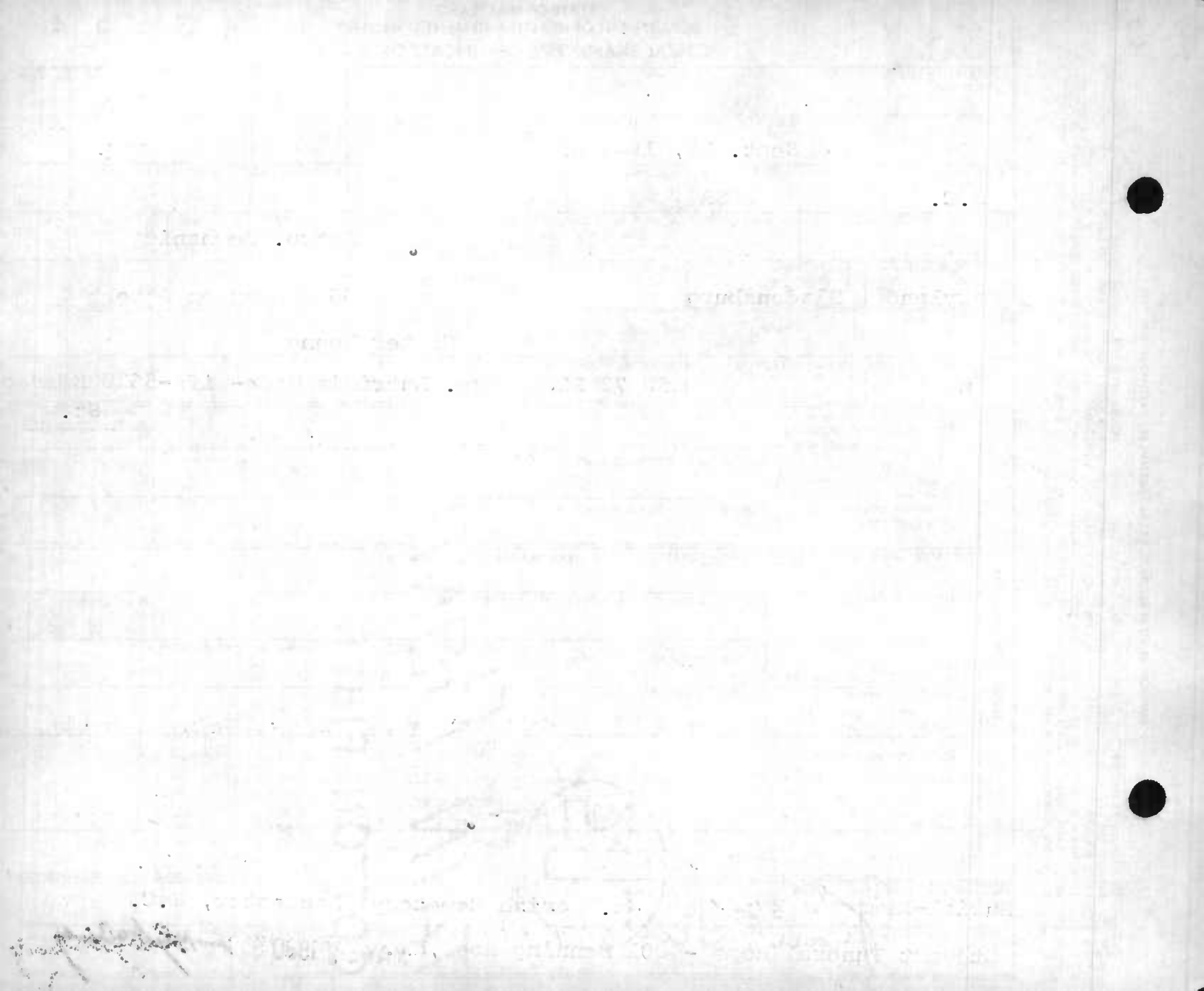
BP

DHMH-17
(VRA15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|--|---|--------------|--------------------------------------|-----------|---|--------------------------|-----------|---------|----------|
| 1. FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH | | 21. MONTH | | 22. DAY | | 23. YEAR | | 24. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 20. DATE KNOWN OF DEATH | | 21. MONTH | | 22. DAY | | 23. YEAR | | 24. HOUR | | |
| JERRY | | 5 13 1980 | | 5 | | 13 | | 1980 | | 11:45 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 24 HRS. | 8. MONTHS | 9. DAYS | 10. HOURS | 11. MIN. | 12. DATE PRONOUNCED DEAD | 13. MONTH | 14. DAY | 15. YEAR |
| Male | Black | Sept. 22, 1944 | 35 | | | | | | 5 13 1980 | 5 | 13 | 1980 |
| 16. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 17. CITIZEN OF WHAT COUNTRY? | 18. MARRIED | 19. NEVER MARRIED | 20. WIDOWED | 21. DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| S.C. | USA | XX | | | | Prince George's County, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Cheverly | Prince George's General Hospital | Metro. Mechanic | | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | | | | | |
| Maryland | Bladensburg | | YES <input type="checkbox"/> NO <input type="checkbox"/> | 5628 Emerson Street | | | | | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| | Hester Young | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | | | | | | | | |
| no | 250 72 2205 | Mrs. Lutricia Wade-wife-5628 Emerson St. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple gunshot wounds with complications | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 11:40 AM 3 13 19 80 | | subject shot | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | home | | 3805 64th Ave. | | Landover | | Prince George's | | Md | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | |
| | | M.D. Deputy Chief | | | | | | 5/14/80 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | |
| Thomas D. Smith, M.D. | | 111 Penn St. Balto., MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY | | STATE | | |
| Burial-Removal | | 5/18/80 | | Mt. Moriah Cemetery | | Lancaster | | S.C. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Stewart Funeral Home | | MAY 3 1980 | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN W WAGNER Sr. | | | 2a. DATE OF DEATH MONTH 5 DAY 28 YEAR 1980 | | 2b. HOUR 4:15A M |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH 12 DAY 4 YEAR 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nash. New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welding Instruction School | | 12b. KIND OF BUSINESS OR INDUSTRY Business |
| 13a. STATE Maryland | | | 13b. COUNTY St. Marys | 13c. CITY OR TOWN Mechanicsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST Jacobe MIDDLE Wagner LAST | | | 15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE Winstanley LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 076-14-8659 | | 17. INFORMANT ADDRESS Ruth B. Wagner Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629 Hemingal carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Small cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 6 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 79 to May 80 , that (I) (we) last saw the deceased alive on 5-27 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kai-Yin Yeung, MD | | DEGREE | | 22c. DATE SIGNED 5-28-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yeung, MD | | 22e. ADDRESS 6525 Belcrest Rd #460 Hyattsville, MD 20782 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/31/80 | | 23c. NAME OF CEMETERY OR CREMATORY Vine Hills Cemetery | |
| 23d. LOCATION CITY OR TOWN Plymouth | | COUNTY Plymouth | | STATE Mass. | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. | | ADDRESS 633 Old Alexander Ferry Road Clinton Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

of the following information:

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13664 | |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FLOYD L. WARD | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 29 1980 | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 7 21 1901 | | 6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 29 1980 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Private | |
| 13a. STATE Maryland | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Clinton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9000 Ballard Lane | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Ward | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kinney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 070-03-6941 | | 17. INFORMANT ADDRESS Sarah W. Ward Same as # 13 a-e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy M.D. | | | | DATE SIGNED 5-30/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs Md. 20031 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jun 2, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1980 | | | | 25b. REGISTRAR'S SIGNATURE Henry McHenry | | | |
| 6633 Old Alexander Ferry Rd. Clinton, Md | | | | | | | | | | | |

2000

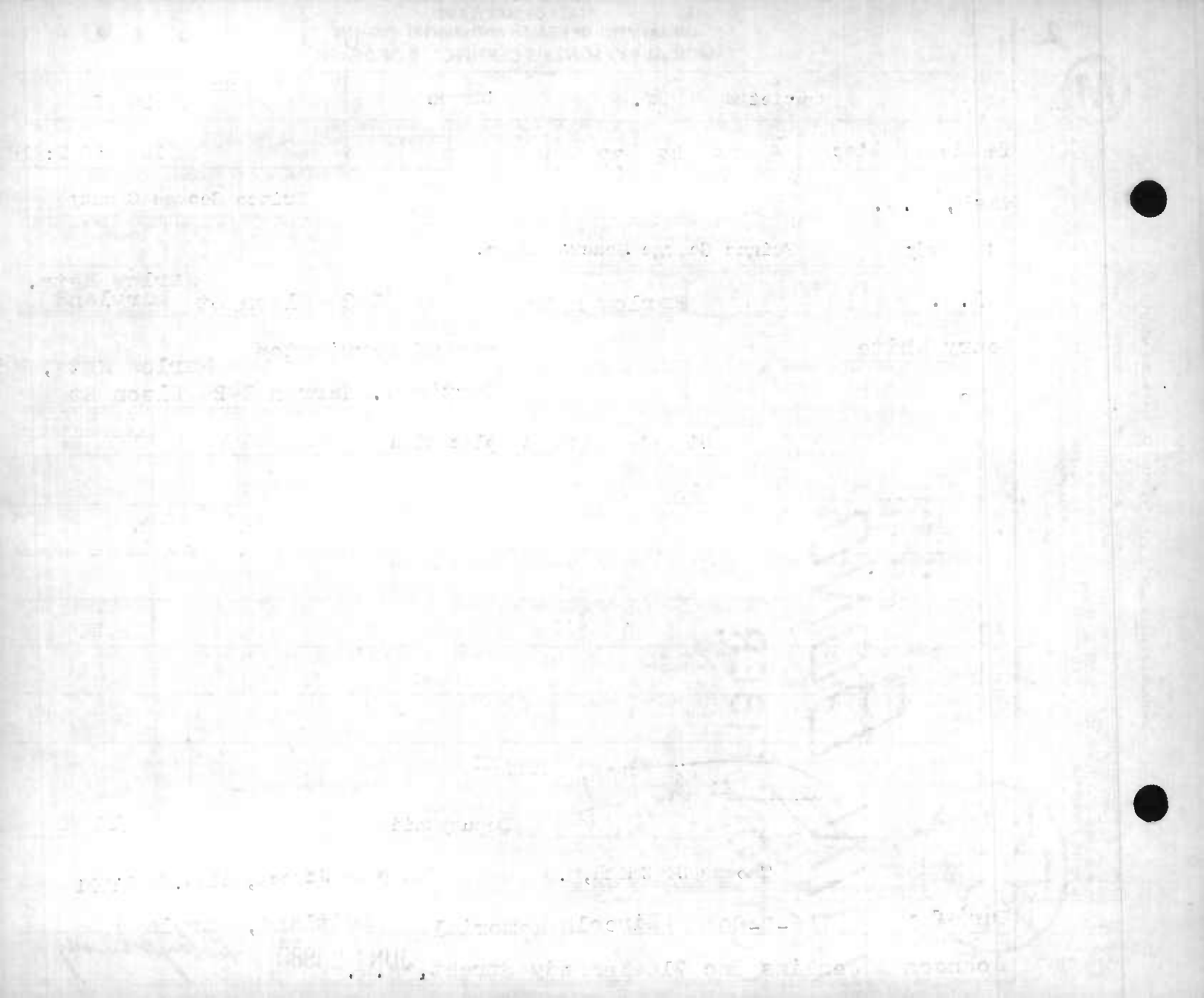
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE DIVISION OF VITAL RECORDS. TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE WITH THE DIVISION OF VITAL RECORDS.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13665 | |
|---|---------|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Harrietta W. Warren | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> 5 30 19 80 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| female | black | 6 25 42 | | 37 YRS. | | MONTHS DAYS HOURS MIN | | | | 5 30 19 80 3:17 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Wash, D.C. | | USA | | | | Prince George County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | Prince George General Hosp. | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| M.D. | | | | PG | | Marlow Hgts | | 2424 Olson St Maryland | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Henry White | | | | Rosebud Harrington | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | | | Curtis W. Warren 2424 Olson St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes with complications</u> 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| Thomas D. Smith, M.D. | | Deputy Chief | | | | 5/31/80 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Thomas D. Smith, M.D. | | 111 Penn Street, Balto, MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 6-7-80 | | Lincoln Memorial | | Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Johnson & Jenkins Inc | | 716 Kennedy Street, N.W. | | JUN 1 2 1980 | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES A WARREN JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/3/80 | | | 2b. HOUR MIN 2:55 PM | | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 18, '42 | | 6 AGE (IN YEARS LAST BIRTHDAY) 38 | | 7a. IF UNDER 1 YEAR MONTHS DAYS YRS. | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD. | | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Community Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Private | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Charles | | 13c. CITY OR TOWN WELCOME | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Route 1 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James A. Warren, Sr. | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST A. Jones | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | |
| 16b. SOCIAL SECURITY NO. 215-38-5114 | | | 17 INFORMANT Ida M. Warren | | | 18 ADDRESS Box 1250, WELCOME, Maryland | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary sarcoidosis DUE TO, OR AS A CONSEQUENCE OF (c) 135- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk year | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/29 , 19 80 , to 5/3 , 19 80 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 5/3 , 19 80 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE H. K. LEE, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/3/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H-K-LEE, M.D. | | | 22e. ADDRESS Clinton Comm. Hospital, Clinton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 8, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Zion Baptist | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hilltop Charles Md. | | | |
| 24. FUNERAL DIRECTOR NAME Leon Thornton | | | ADDRESS Pomonkey, Md. | | | 25a. DATE RECEIVED BY REGISTRAR MAY 7 1980 | | 25b. REGISTRAR'S SIGNATURE John H. H. H. | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

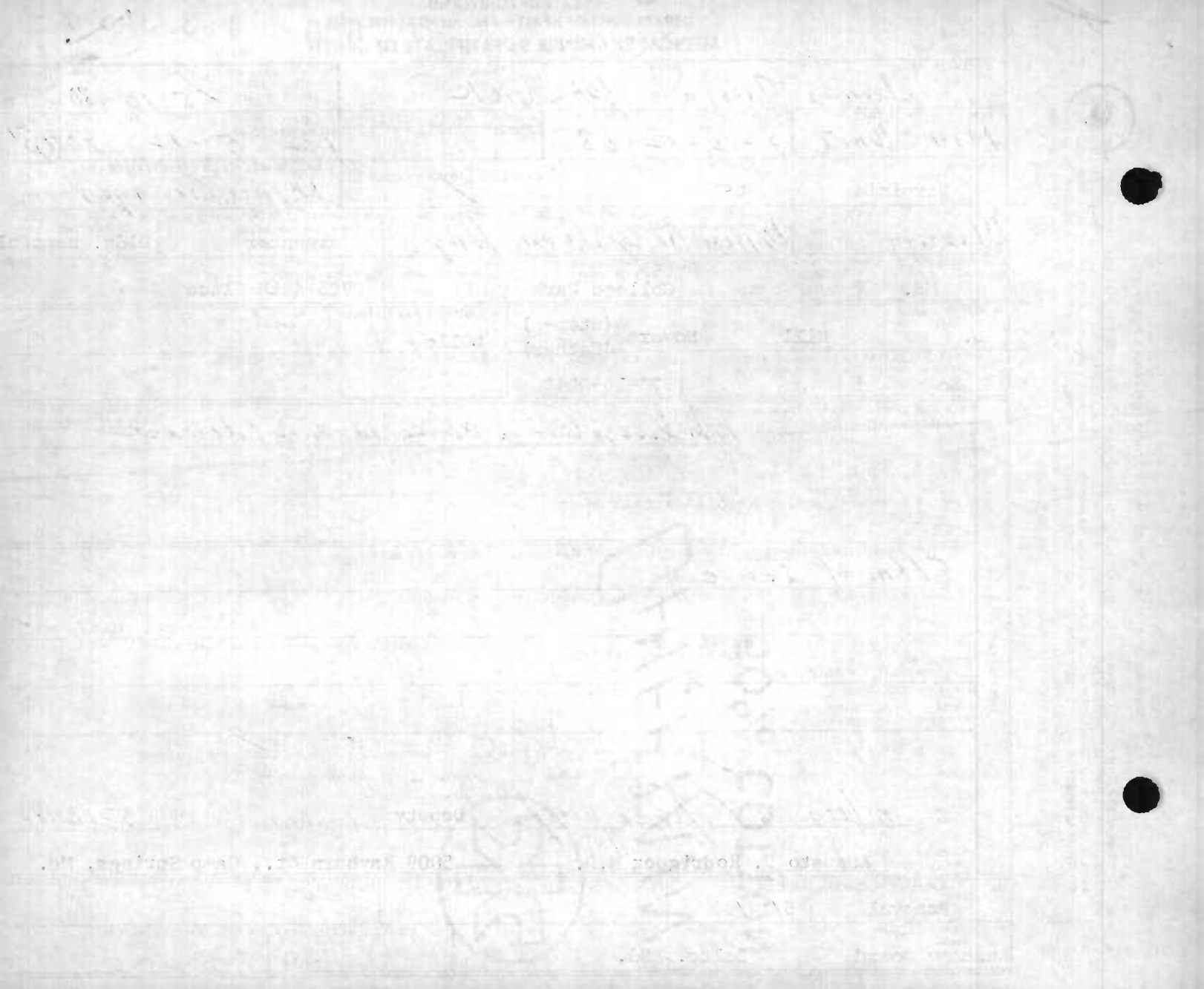
TO : DIRECTOR, FBI (100-371144)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]
DATE: [Illegible]
CLASS: [Illegible]
[Illegible text block containing various details and references]

[Large block of illegible text, likely the main body of the report or letter]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13667 | |
|---|--|----------------------|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>James Calvin</i> <i>WARWICK</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>5-10-80</i> | | | | | | | | | | 2b. HOUR <i>M</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH <i>3</i> DAY <i>2</i> YEAR <i>12</i> | | 6. AGE (IN YEARS) LAST BIRTHDAY <i>68</i> YRS | | 7. IF UNDER 1 YR. MONTHS <i>00</i> DAYS <i>00</i> | | 8. IF UNDER 24 HRS. HOURS <i>00</i> MIN <i>00</i> | | 7c. DATE PRONOUNCED MONTH <i>5</i> DAY <i>12</i> YEAR <i>1980</i> | | 7d. HOUR <i>4:31</i> <i>M</i> | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Gen. Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Carpenter</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Bldg. remodel</i> | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE <i>Md.</i> | | | | 13b. COUNTY <i>P.G.</i> | | | | 13c. CITY OR TOWN <i>College Park</i> | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS <i>8705 48th Place</i> | | | | | |
| 14. FATHER'S NAME FIRST <i>L.</i> MIDDLE <i>Hill</i> LAST <i>Bowers (step- father)</i> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Belle</i> MIDDLE <i></i> LAST <i></i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>578-10-0842</i> | | | | 17. INFORMANT ADDRESS <i></i> | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Arteriosclerosis caused vascular disease</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Ethanol Abuse</i> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER | | | | DATE SIGNED <i>5-13-80</i> | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez M.D.</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md.</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | | | 23b. DATE <i>5/14/80</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Antony Board</i> ADDRESS <i>Balto., Md.</i> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 15 1980</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Anthony Board</i> | | | | | | | |

7000 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) WILLIAM H. WASHINGTON | | | 2a DATE OF DEATH MONTH DAY YEAR 05 18 80 | | | 2b HOUR 11:35PM | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 12-26-1915 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS | | 7 UNDER 1 YEAR MONTHS DAYS 00 00 | | 8 UNDER 24 HRS HOURS MIN 00 00 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY, MD. | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. HOSP. & MED. CTR. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard | | 12b KIND OF BUSINESS OR INDUSTRY Security | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D.C. | | 13b COUNTY N/A | | 13c CITY OR TOWN Washington | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 5304 Sheriff Rd., N.E. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Walter Washington | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Johnson | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO 518-14-4727 | | 17 INFORMANT ADDRESS Joyce Taylor-418 Birchleaf Ave., MD. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. Cardiopulmonary arrest 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ac myo. infarction probably DUE TO, OR AS A CONSEQUENCE OF (c) coronary art. dg. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cardiac arrhythmias | | | | | | | | | | | |
| 19a DATE OF OPERATION — | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR — — — 19 P.M. | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from March , 19 80 , to May 18 , 19 80 , that (I) (we) last saw the deceased alive on May 18 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE A. Jariwala MD. | | | | DEGREE MD. MBS | | 22c DATE SIGNED 5/19/80 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. JARIWALA | | | | 22e ADDRESS Prince Georges Gen Hosp, Cheverly MD. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 5-24-80 | | 23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Highland Park Md Prince Georges | | | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E. | | | | 25a DATE OF REGISTRATION MAY 26 1980 | | | | | | | |

| | | | |
|--------|-------------|------------------|---------------------|
| Male | Black | 12-26-1915 | 64 |
| D.C. | U.S.A. | x | Security |
| D.C. | W/A | Washington | x |
| Walter | Washington | Elizabeth | Johnson |
| No | 518-14-4727 | Joyce Taylor-418 | Birchleaf Ave., Md. |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) MONTROSE | | | 2a DATE OF DEATH MONTH DAY YEAR 05-18-80 | | | 2b HOUR 6:00AM | | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 73 | | 7a IF UNDER 1 YEAR MONTHS DAYS YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD. | | | | |
| 10 CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE Maryland | | | 13b COUNTY Cheverly | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 5505 Monroe Street | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Monroe Waters | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Wise | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b SOCIAL SECURITY NO 579 03 8307A | | 17 INFORMANT 5505 Monroe Street-Cheverly, Md. Mrs. Gertrude Waters-wife | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHO PNEUMONIA 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) PULMONARY EDEMA (c) HISTIOCYTIC LYMPHO DISSEMINATED PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 574 P.M. 19 80 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE 5718 SV | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 574 19 80 , to 5718 19 80 , that (1) (we) lost 5718 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (over) (did) (did not) view the body after death. | | | | | | | | | 22c DATE SIGNED 5/18/80 | |
| 22b SIGNATURE Lewis H. Dennis | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS H. DENNIS, M.D. | | | 22e ADDRESS 831 UNIVERSITY BLVD.E. SILVER SPRING, MD. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE May 23, 1980 | | 23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | | 23d LOCATION CITY OR TOWN COUNTY STATE Landover Maryland | | |
| 24 FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE. | | | 25 DATE REC'D. BY REGISTRAR MAY 23 1980 | | | 25b REGISTRAR'S SIGNATURE [Signature] | | | | |

PRINCE GEORGE'S GENERAL HOSPITAL

UNCLASSIFIED//FOR OFFICIAL USE ONLY

QIBEI D. S. YAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Galen Wehn | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 3, 1980 | | 2b. HOUR 12:43 ^{PM} | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 7/28/11 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD | | | | | |
| 10 CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Machines | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. Co. | | 13c. CITY OR TOWN Seabrook | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9307 Good Luck Road | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edward E. Wehn | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha N. Holliday | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. IF YES, GIVE WAR OR DATES WWII | | 16c. SOCIAL SECURITY NO. 579-10-8099 | | 17 INFORMANT ADDRESS Helen K. Rice (Cousin) Same as # 13. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulmonary disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Myocardial infarction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>5/12/80</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>80</u> , to <u>5/3</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. E. Jones, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/12/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. Jones, M.D. | | | | 22e. ADDRESS 4235 28th Ave NW | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May/7/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veteran's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G. Co., Maryland | | | | | |
| 24 FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | ADDRESS Riverdale, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAY 9 1980 | | 25b. REGISTRAR'S SIGNATURE Tiffany McCreedy | |

Richard
 John
 2
 18
 Prince George County, Va.
 Southern Maryland Hospital
 18.00.00
 1800

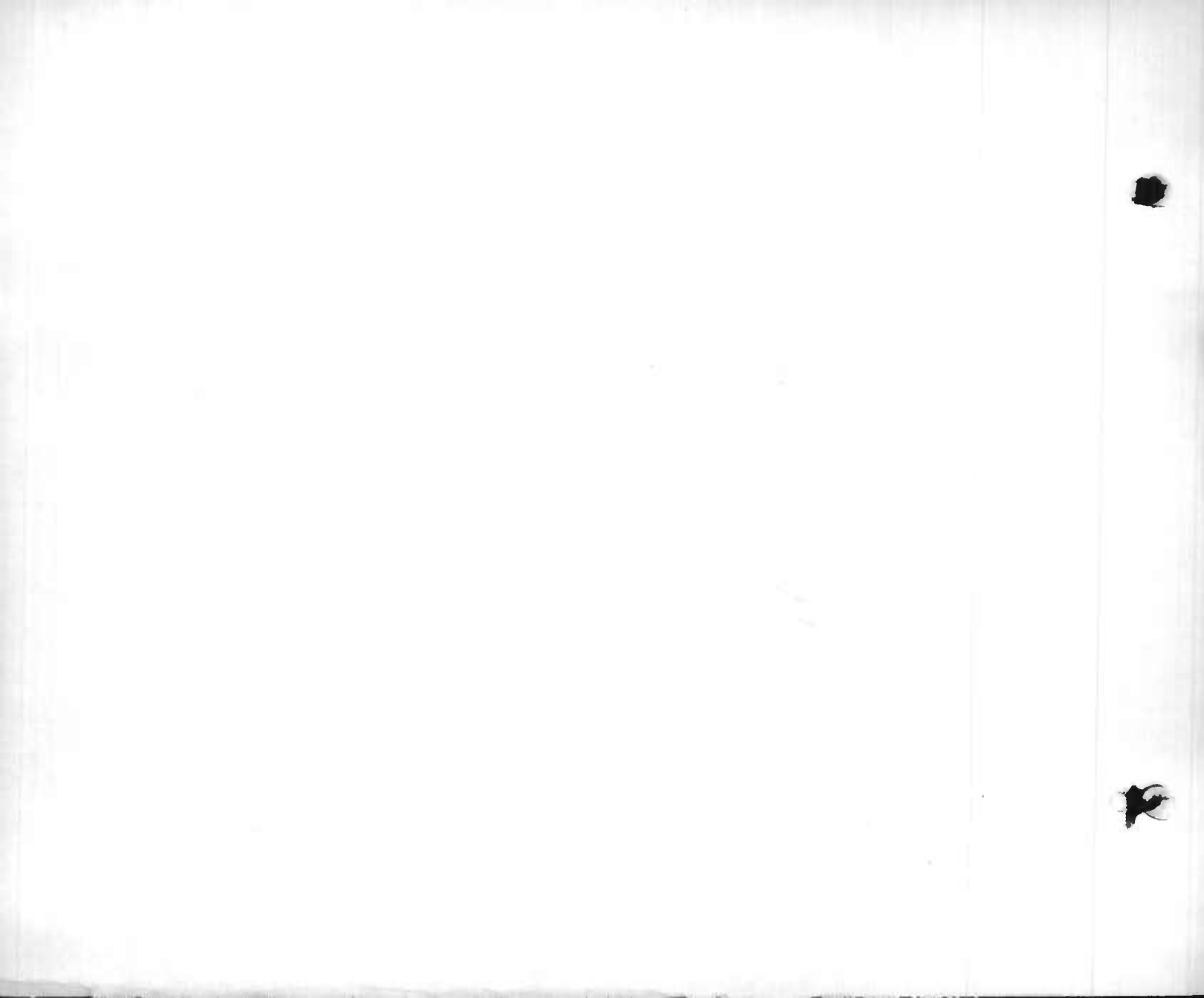
270-10-0000
 Richard
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VOID

#80-13671



Items 18c & Pt.2 G544 6/6/80
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Faith A. Weisiger | | | 2a. DATE OF DEATH MONTH DAY YEAR May 12, 1980 | | | 7b. HOUR 7:18a M | |
| 1. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 21, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of P. G. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR ADULTS OR WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Md. | | 13b. COUNTY P. G. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 6902 Highview Terrace # 202 | | 14. FATHER'S NAME Clarence F. Clements | | 15. MOTHER'S MAIDEN NAME Sarah F. Travis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-3064 | | 17. INFORMANT Paul F. Mattingly, Same as # 13 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Myeloproliferative disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>Diabetes</u> (b) <u>Essential hypertension</u> (c) <u>Myeloproliferative disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13/80</u> to <u>May 12, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | |
| 22b. SIGNATURE <u>Lewis Hilliard Dennis</u> | | | | DEGREE M.D. | | 22c. DATE SIGNED 5/13/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Hilliard Dennis, M.D. | | | | 22e. ADDRESS 831 University Blvd Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/15/80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCready</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | REG. NO. | |
|--|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT L. WELCH | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 29 1980 | | 2b. HOUR 8:50A M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 29 1902 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. IF UNDER 24 HRS HOURS MIN. 0 0 | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heating Eng. | | |
| 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 9211 Stuart Lane | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Welch | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Franklin | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | |
| 17. SOCIAL SECURITY NO. 577-05-6405 | | 18. INFORMANT Rt. 2, Box 147H Waldorf, Md. | | 19. Elizabeth Hutchinson, Daughter | | |
| 10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Lymphoma (malignant) (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Congestive Heart Failure | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 5/29/80 , 19 80 , to 5/29/80 , 19 80 , that (I) (we) last saw the deceased alive on 5/29/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE R. M. Brown, MD | | DEGREE MD | | 22c. DATE SIGNED 5/29/80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) REZA MOSTAFAEI | | 22e. ADDRESS 4235 28th Ave nd 20031 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-31-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Md. | | 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1980 | | |
| 24. FUNERAL HOME Funeral Home | | 25b. REGISTRAR'S SIGNATURE John J. McCreedy | | 25c. ADDRESS 4308 Suitland Rd., Suitland, Md. | | |

BP



Cooper's Heart for Love
Lupinus albus
Lupinus albus

1852 1852
1852 1852
1852 1852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 0 1 3 6 7 4 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | | | | | | | REG. NO. | |
| FIRST MIDDLE LAST | | | | | | | | | | 2r. DATE OF DEATH | |
| Alina E. Went | | | | | | | | | | MONTH DAY YEAR | |
| | | | | | | | | | | 05 05 80 | |
| 3 SEX | | | | | | | | | | 2b. HOUR | |
| Female | | | | | | | | | | 4:20am | |
| 4 RACE | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Caucasian | | | | | | | | | | 71 YRS. | |
| 5. DATE OF BIRTH | | | | | | | | | | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| MONTH DAY YEAR | | | | | | | | | | Prin George's MD. | |
| 08 31 08 | | | | | | | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| MONTANA | | | | | | | | | | None | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| USA | | | | | | | | | | Household | |
| 10 CITY OR TOWN OF DEATH | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clinton | | | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Southern Maryland Hospital | | | | | | | | | | Household | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | |
| Maryland | | | | | | | | | | Prince Geo. | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | |
| Temple Hills | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME | | | | | | | | | | 15 MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | |
| Walle Kivinen | | | | | | | | | | Liisa Pentilla | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 17 INFORMANT ADDRESS | |
| None | | | | | | | | | | Thomas F. Wert, same as #13 | |
| 16b. SOCIAL SECURITY NO | | | | | | | | | | 17 INFORMANT ADDRESS | |
| 578-01-4530 | | | | | | | | | | Thomas F. Wert, same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1629 CARDIOPULMONARY ARREST | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| CARCINOMA of LUNG with | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| METASTASIS | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY | |
| | | | | | | | | | | HOUR A.M. MONTH DAY YEAR | |
| | | | | | | | | | | P.M. 19 | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | | | | |
| 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | 21g. LOCATION | |
| | | | | | | | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/15, 1973, to 5/5, 1980, that (I) (we) lost saw the deceased alive on 5/5, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE | | | | | | | | | | 5/5/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| Gurbux Nachnani | | | | | | | | | | 9015 Woodyard Rd., Clinton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | |
| Cremation | | | | | | | | | | May 6, 1980 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | |
| Lee's Crematory | | | | | | | | | | Washington, D.C. | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE RECEIVED BY REGISTRAR | |
| Lee Funeral Home, Clinton, Maryland | | | | | | | | | | MAY 12 1980 | |



05 05 00 4:50a

Female Caucasian 05 05 00

Prince George's

Clinton Southern Maryland Hospital

Maryland Prince Geo. Temple Hills 3073 Brinkley Road

Male African American 3073 Brinkley Road

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

3073-01-4530 Prince George's County, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 13075 | |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 2- DECEASED NAME FIRST MIDDLE LAST Vernon N Whiteing | | | | | | | | | | 2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-22 1980 | |
| 3- SEX Male | | 4- RACE Black | | 5- DATE OF BIRTH MONTH DAY YEAR 7-28-25 | | 6- AGE (IN YEARS) LAST BIRTHDAY 53 YRS. | | 7- IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-22 1980 | |
| 8- BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D. C. | | 9- CITIZEN OF WHAT COUNTRY? U. S. A. | | 10- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11- BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | 12- BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | 13- BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | |
| 14- CITY OR TOWN OF DEATH Cheverly (DOA) | | 15- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS Prince Georges General Hospital | | 16- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER GOV'T | | 17- KIND OF BUSINESS OR INDUSTRY | | | | | |
| 18- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY PRINCE GEORGE | | 13c. CITY OR TOWN OXON HILL | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 864 NEPTUNE AVENUE | | | |
| 14- FATHER'S NAME FIRST MIDDLE LAST ROBERT G WHITEING | | 15- MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE V DELANEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 578 22 1588 | | 17. INFORMANT BARBARA BISHOP | | ADDRESS CLINTON, MD 11400 AGCOLADE CT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) M.D. Deputy | | | | DATE SIGNED 5-23-80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5-28-80 | | | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY PARK | | | |
| 23d. LOCATION CITY OR TOWN LANDOVER | | | | COUNTY MD. | | | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME JAMES T. SUTTON | | | | ADDRESS 5635 EADS ST. N.E. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | | |
| 25b. REGISTRAR'S SIGNATURE Rufus Kelley | | | | | | | | | | | |

FOR THE YEAR 1900
OF THE UNITED STATES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|-----------------------------------|---------------------|----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Marie Louise Whitley | | | 2a. DATE OF DEATH MONTH DAY YEAR May 8, 1980 | | | 2b. HOUR 7:30 AM | |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 9, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George | 13c. CITY OR TOWN Laurel | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Pascal Williams | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah McDowell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No. | | 16b. SOCIAL SECURITY NO. 212-74-1688 | | 17. INFORMANT James R. Whitley | | | |
| | | | | ADDRESS 15713 Bond Mill Rd. Laurel, Md. 20810 | | | |

| | |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>respiratory failure</u> 492- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>emphysema & old car accident</u> | |
| 19a. DATE OF OPERATION 9/9 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. ALLOPATHY YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> 19 <u>75</u> , to <u>May 8</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 7</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | |
| 22b. SIGNATURE <u>[Signature]</u> | 22c. DATE SIGNED May 8, 1980 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |

| | | | |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (USE CITY) Burial | 23b. DATE 5/12/80 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Co. Md. |
| 24. FUNERAL DIRECTOR ELEEK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810 | | 25a. DATE REC'D. BY REGISTRAR MAY 9 1980 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

UNITED STATES

May 8 1980

For the



Female White Tail Deer

North Carolina N.S.

Washington State

May 8 1980

Handwritten signature or name.

Handwritten text, possibly a date or location.

May 8 1980

May 8

Handwritten signature or name.

May 8 1980

May 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 3 6 7 7

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNIE WILLIAMS | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 14 80 | | | 2b. HOUR 12:15A.M. | | | | | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 01 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7. # UNDER 1 YEAR MONTHS DAYS | | 8. # UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2621 Oxon Run Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unavailable | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unavailable | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. Unavailable | | 17. INFORMANT 27. Address: Ezell J. Williams, Hillcrest Heights, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Accelerated Senile Hypertension.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Renal failure, Congestive heart failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-8-1980</u> to <u>5-14-1980</u> , that (I) (we) lost saw the deceased alive on <u>5-13-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Emmery</u> M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | | | 23b. DATE Park, 5-17-80 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md. | | | |
| 24. FUNERAL DIRECTOR NAME W.H. Bacon Funeral Home | | | | ADDRESS 3447-14th St. N.W. Washington, D.C. | | 25. DATE REC'D. BY REGISTRAR MAY 15 1980 | | 26. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u> | | | |



MAY 12 1980

8



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMM - 16 60M 7/73
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE WILLIAMS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 21 80 | | | | | 2b. HOUR 2:35 P.M. | |
| 3. SEX F | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 18 95 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH LAUREL | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | |
| 13a. STATE Md | | 13b. COUNTY PG | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 45A Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edgar Wine's | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Pomeroy | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 20 0319 | | 17. INFORMANT ADDRESS Irene White same as above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident, massive DUE TO, OR AS A CONSEQUENCE OF (c) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 5/12/80 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 19 77 to May 21 19 80 , that (I) (we) last saw the deceased alive on May 21 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William A. Warren | | | | | | DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/21/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm A. Warren | | | | | | 22e. ADDRESS 321 PRINCE GEORGE ST. LAUREL, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 23, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Savage, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Donaldson W.H. Howard, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE Robert M. Brandy | | | |

0103 BP

CHARGE, HATFIELD

CHARGE, CHURCH

CHARGE, CHURCH

CHARGE, CHURCH

LINE 20 0319 LINE WHITE SAME AS ABOVE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---------|--|---|--|--|---------------------------------|--|--|--------------------|--|--------------------|--|--|--|--|--|--|----------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 0 1 3 6 7 9 | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| PHYLLIS A. WILLIAMS | | | | | 05 27 80 | | | | | 6:30 AM | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | | | | | | | | | |
| female | | | white | | Jan 28, 1919 | | | 61 years YRS. | | | MONTHS | | DAYS | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | | | | |
| Washington D C | | | | | U S A | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| CHEVERLY | | | | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | | Telephone | | | | | Operator | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. INSIDE CITY LIMITS? | | | | | 13b. STREET ADDRESS | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | 13c. STREET ADDRESS | | | | | | | | | |
| Md | | | | | | | | | | Pro Georges Mt Rainier | | | | | 3801 33rd Street | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| Unknown | | | | | | | | | | Unknown | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO | | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| no | | | | | | | | | | 579 30 6074 | | | | | Douglas Dudrow Hyattsville, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage | | | | | | | | | | | | | | | | | | | | | | | | |
| 2848 | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Severe Pancytopenia | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | |
| C.O.P.D. & C.H.F. | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED | | | | | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21e. INJURY OCCURRED | | | | | 21f. PLACE OF INJURY | | | | | 21g. LOCATION | | | | | 21h. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | STREET | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3, 19 27, to 5-27-19 80, that (I) (we) last saw the deceased alive on 5-27-19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Sukumaran Aryangat | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 5/27/80 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| SUKUMARAN ARYANGAT, M.D. | | | | | | | | | | 3308 PERRY ST. MT. RAINIER, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | | | | | | |
| Burial | | | | | June 2, 1980 | | | | | Ft Lincoln Cemetery | | | | | Brentwood Pro Georges Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| F. Gasch's Sons P A | | | | | | | | | | Hyattsville, Md. | | | | | JUN 4 1980 | | | | | [Signature] | | | | |

SUKURAN WYNGAT, N.D. 3708 PERRY ST. 177 RAINIER, ID.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Jeannette P. Wilson | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 4 1980 | | | | | 2b. HOUR 2:55 PM |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1887 | | 6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | |
| 10 CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow U.S.A.F. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY None | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY P.G. 13d. CITY OR TOWN Hilcrest Heights | | | | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS 2118 Gaither Street | | | |
| 14 FATHER'S NAME FIRST Richard MIDDLE Townsend LAST Townson | | | | | 15. MOTHER'S MAIDEN NAME FIRST Sallie Ann MIDDLE Carter LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 069-22-5066 | | 17 INFORMANT ADDRESS D Alice Wilson same as #13 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1809 DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular disease | | | | | | | | | | 1973 → 1980 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 APRIL 1980 , to 4 MAY 1980 , that (I) (we) lost saw the deceased alive on 4 MAY 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Martin Greget MD | | | DEGREE Intern | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED May 4, 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Greget MD | | | 22e. ADDRESS MGM | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 5/8/80 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN Arlington COUNTY Virginia STATE | | | |
| 24 FUNERAL DIRECTOR'S NAME Lee Funeral Home Inc. | | | 24b. ADDRESS 6633 Old Alex, Ferry Rd. Clinton Md. | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE Reddy | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|
| FOR 1- STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA V. WINGOOD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 30 1980 | | | 2b. HOUR 7:10 P.M. | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR 4 25 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD. | | | |
| 10 CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Convalescent Cen. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY Pr. Geo | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST Noah J. Hyle | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie E. Litener | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-74-6347 | | 17 INFORMANT ADDRESS William E. Wingood, Jr. Same as # 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest. 4409 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive heart failure (c) Generalized arteriosclerosis. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) dry gangrene of right hand. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/10/80 19 to 5/30 19 80, that (1) was lost saw the deceased alive on 3/27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE ROBERTO A. DE PETRIS | | | | | DEGREE MD | | | 22c. DATE SIGNED 5/30/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS 6776 Race-track Rd Bowie Md 20715 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6-2-80 | | 23c. NAME OF CEMETERY OR CREMATORY Lorrain Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Howard Md. | | |
| 24 FUNERAL DIRECTOR NAME Beall Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 10 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony A. Budy | | |
| 16,000 Annapolis Rd. Bowie, Md. | | | | | | | | | |

16,000 Annapolis Rd. Bowie, Md.
Beall Funeral Home
6-2-80 Lorraine Cemetery Woodlawn Howard Md.

No 213-74-6347 William E. Windood, Jr. 2 me as # 13

North J. Hyle Jennie E. Litterer

Mr. Pr. Geo. Bowie 3310 Moreland Pl.

Greenbelt Greenbelt Convalescent Cen. Housewife

Maryland U.S.A. x Pr. Geo.

Female Caucasian 25 1890 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|-----------------------------|---|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) EDNA R WINLEY | | | 2a DATE OF DEATH MONTH DAY YEAR 5 21 80 | | | 2b HOUR 3:40 PM | | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR 7 29 17 | | 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD | | | |
| 10 CITY OR TOWN OF DEATH CLINTON | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MD HOSP CENTER | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC | | 12b KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | | 13b COUNTY PR. GEORGE | | 13c CITY OR TOWN CLINTON | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST DAVID WINDLEY | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELL BREWER | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-30-8686 | | | 17 INFORMANT ADDRESS Forest HGTS. Md. ILLA JETER/daughter/200 Seneca Drive. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia and Sepsis.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cognitive memory failure.</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (this hospital) attended the deceased from <u>5/19/80</u> to <u>5/21/80</u> , that (we) last saw the deceased alive on <u>5/21/80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death) | | | | | | | | | |
| 22b SIGNATURE <u>M. NEMATZ</u> M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED 5/21/80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) M. NEMATZ | | | | 22e ADDRESS 4235.28th Ave #612. Marlow Heights Md. 2003 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE MAY 27, 1980 | | 23c NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY | | 23d LOCATION CITY OR TOWN COUNTY STATE LANDOVER Pg Maryland | | | |
| 24 FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. | | | | ADDRESS 4339 HUNT Place, N.E. | | 25a DATE REC'D. BY REGISTRAR MAY 26 1980 | | | |
| | | | | | | 25b REGISTRAR'S SIGNATURE <u>Robert McCreesh</u> | | | |

RECEIVED
JAN 10 1968

MAY 27 1960 - HANOVER BY CUMMERTON

TRACIN (EVAC)

2000

0528-05-152

[illegible]

Forest Dept.

INDEX

STATE OF OHIO

ANTHONY R. BROWN

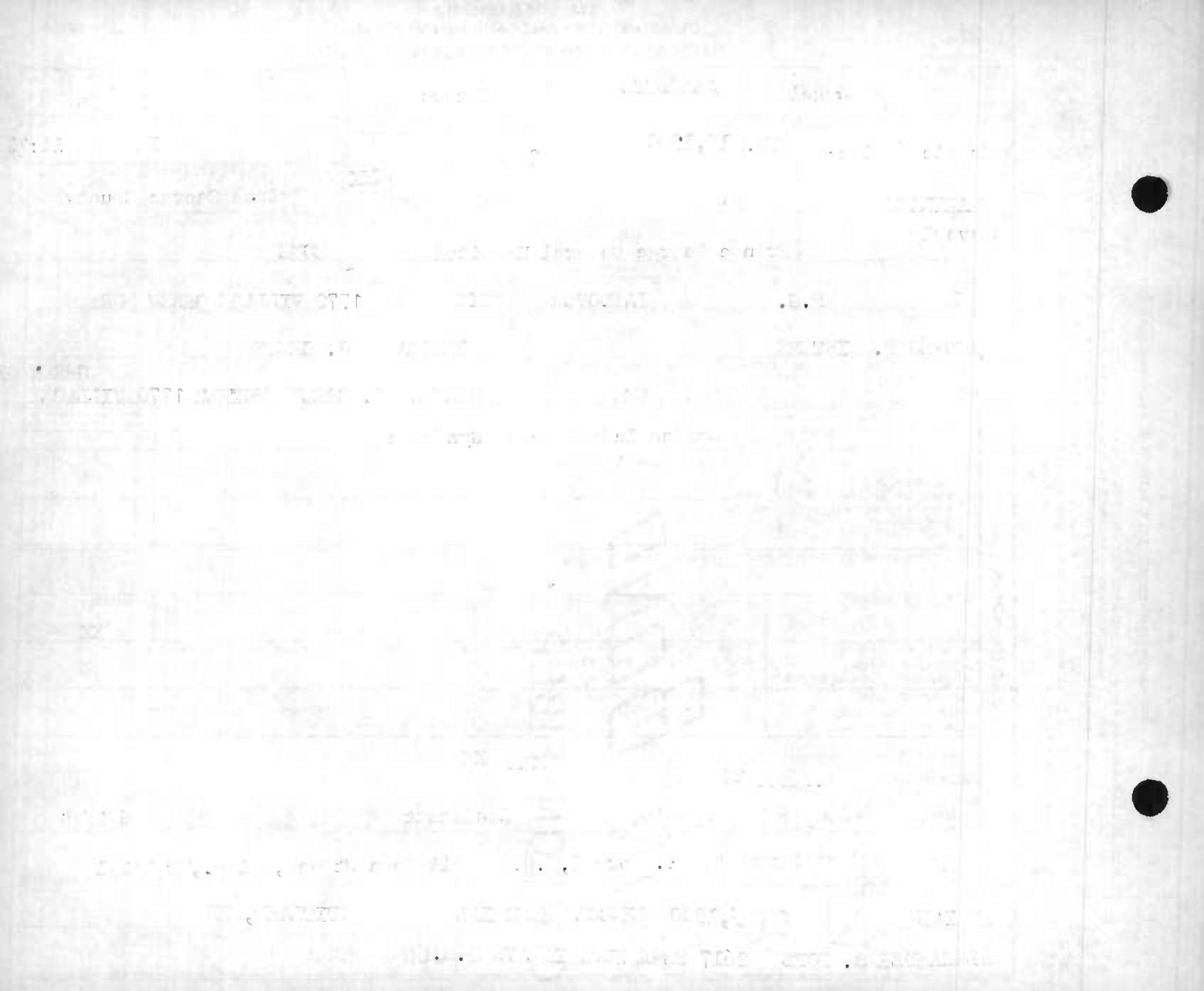
CITIZENS

10/10/2001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR 15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 3 6 8 3 | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Angel JEANETTE Winters | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 31 19 80 | | 2b. HOUR M 11:23 | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR MAR 19, 1980 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS 2 2 | | IF UNDER 1 YR. IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 31 19 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN LANDOVER | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1770 VILLAGE GREEN DR | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ANDREW P. WINTERS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRENDA J. GREEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. UNK | | 17. INFORMANT ADDRESS BRENDA J. GREEN MOTHER 1770 VILLAGE GREEN DR | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Sudden Infant Death Syndrome IMMEDIATE CAUSE (a) 7980 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 6/2/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JUN 5, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, MD | | | |
| 24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE | | | | 25a. DATE REC'D. BY REGISTRAR JUN 9 1980 | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 13684 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JICE | | ZIMMERMAN | | | | | | 04-08-80 | | 12:45AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| M | | W | | 12-2-1900 | | 79 YRS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| L.A. | | U.S.A. | | | | PRINCE GEORGES MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CHEVERLY | | PRINCE GEORGES GENERAL HOSPITAL | | | | | | Retired | | Painter | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| MD | | P.E. | | Cap. Hots | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 24 Hiken Ave | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Willie Zimmerman | | | | Betty Harris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | | | | | |
| YES | | WW2 | | 437-01-3931 | | Helen Zimmerman 5411 H 13 E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE. | | | | | | | | | | | |
| 4414 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute or Chronic Renal Failure. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertensive heart cardiovascular disease, 3P Abdominal Aneurysmectomy. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3-13-80. | | Abdominal Aortic Aneurysm | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from 3-13-1980 to 4-8-1980, that (he) (we) last saw the deceased alive on 4-8-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| [Signature] | | | | 4-8-80. | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| GANDHISI YALAMAN CHIKI | | | | PG Hospital Cheverly MD 20725 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| | | 4-12-80 | | Harmony Cem. | | Highland Park | | MD | | STATE | |
| 24. FUNERAL DIRECTOR NAME | | | | 24. ADDRESS | | | | 25a. DATE DEC. BY REGISTRAR | | | |
| H. S. Washington 4425 | | | | 11. Buchanan's Ave NE | | | | APR 13 1980 | | | |

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SAINT GEORGE

SAINT GEORGE'S GENERAL HOSPITAL